Child & Adolescent Mental Health Services

Strategic Plan 2003 – 2006

"Fostering strong futures for Hawaii's children, families and communities"

Child & Adolescent Mental Health Division
Department of Health
State of Hawaii

Preface

The Child & Adolescent Mental Health Division (CAMHD) Strategic Plan represents a substantial effort by the CAMHD Management Team, Hawaii Family As Allies (HFAA), Community Children's Council (CCC), and the State Mental Health Council.

This plan marks an important step in the evolution of the children's mental health system. By engaging broadly with stakeholders, CAMHD has developed a plan that is reflective of the input and efforts of many individuals and agencies across the state. In the development of this plan, input was obtained from all child serving entities, community organizations, provider agencies, legislative representatives, and family members. This input has served as the foundation for the development of CAMHD broad goals and key strategic initiatives.

This plan identifies strategies to meet goals and outlines expectations for periodic review of the objective measures. The CAMHD Management Team will provide routine feedback to stakeholders regarding the implementation efforts as outlined in this plan.

CAMHD wishes to thank Sharon Nobriga and Vicky Followell, all HFAA Parent Partners, Patrick England, all CCC Co-Chairs, Shelly Ogata, all members of the State Mental Health Council, and all stakeholders for their participation in this plan development.

By working together we learn from each other, strengthen the plan, and develop an effective and efficient mental health system for the children and families of Hawaii.

Mahalo for your time and energy.

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Executive Summary

Every school knows of them. Each community surrounds them. All of our families or extended families have direct experiences with them. These are our children and youth with emotional and behavioral challenges. As many as 30,000 children and youth in our state are estimated to experience some degree of impairment. Some of these children go unnoticed or misunderstood. Some go untreated. Others are so very obvious to our teachers and community leaders that they command our attention.

With early identification and proper treatment, many of these children go on to lead fully involved and productive lives. Without proper support and services, too many of these children end up in the juvenile justice system, with substance abuse issues, homeless, and worst of all, by ending their lives.

Over the past decade, Hawai'i's child and adolescent mental health system has grown tremendously in its capacity to serve these children and youth. This growth has been guided by the settlements of two class action lawsuits, the Felix Consent Decree and the Department of Justice Settlement Agreement. The Child & Adolescent Mental Health Division (CAMHD) has also been guided by the statewide implementation of school-based mental health and through the partnership with the Statewide Family Organization, Hawaii Families As Allies (HFAA).

The changes within CAMHD have been rapid. There has been substantial progress with key strategic efforts put forth by the state. Our state now faces the challenge of integrating all of these very important initiatives into a unified approach and consistent practice with children and families.

The primary areas requiring attention and effort over the next four- (4) years can be categorized into 5 broad goals. These goals include ensuring commitment to the initiatives, maintaining the core system foundation as guided by the Child & Adolescent Service System Program (CASSP) principles, disseminating evidence based services in all communities, sustaining and enhancing front line monitoring and evaluation of the system, and solidifying business practices to ensure accountability.

To effectively implement the strategies and achieve the goals set forth in this plan, there is a need to ensure stable funding and personnel allocations, as well as ensure stable leadership and support of these activities. With stability in these areas, the children's mental health system will continue to make commendable progress towards effectively serving the state's children and youth with emotional challenges.

SECTION I

Overview of Child & Adolescent Mental Health Issues

Emotional Disturbance Nationally

It is estimated that as many as 7.5 million children and youth in the United States have a diagnosable mental health disorder, with as many as 3.5 million seriously affected by the emotional or behavioral disorder (Institute of Medicine, 1989). The challenges experienced by these children and youth range from anxiety, depression and other mood disorders to Attention Deficit Hyperactivity Disorder (ADHD), oppositional defiant and other behavioral disorders. These disorders, with varying degrees of intensity, impact the child's ability to perform in school, develop and maintain healthy relationships with family and friends, and impact how the child interacts with the community at large. Those youth that experience the greatest level of impairment in their day to day functioning are often classified as experiencing Serious Emotional Disturbance (SED) or Serious Emotional and/or Behavioral Disturbance (SEBD). These two terms are synonymous and often used interchangeably. In many communities across the country, SEBD is preferred term so this is the term most often used in this document.

The only difference between those youth labeled with emotional disturbance and those with serious emotional disturbance is the degree of impairment that they experience in day to day life. It is often difficult to approximate the exact prevalence of children and youth with SEBD because there is wide variation in the methods used to determine this level of functional impairment. Broadly speaking, it is accepted that 5-9% of the child population experiences some level of emotional disturbance at some point in their childhood. Those children and youth experiencing the greatest level of functional impairment, those with SEBD, is estimated at 5% of the general population, from birth to 18 years.

Without early identification of needs, thorough assessment and effective treatment, children and youth with SEBD often present in our nation's juvenile justice system, child welfare system, substance abuse programs, and most unfortunately, as a statistic in the our nation's growing trend of adolescent suicide (U.S.P.H.S. Report of the Surgeon General, 2000). Since 1960, the rate of adolescent suicide has tripled, with suicide being the third leading cause of death for individuals ages 15-19 years (Vitanza, S., Cohen, R., & Hall, L., 1999). In addition to these very serious problems, youth with SEBD often experience challenges in transitioning to a meaningful and productive adult life (National Technical Assistance Center for State Mental Health Planning. 2002).

In order to provide some national direction to the varying definitions of SEBD, and standardize the use of the term, the federal Center for Mental Health Services (CMHS), a division of the Department of Health & Human Services (DHHS), offered a definition of "children with serious emotional disturbance." For general discussion purposes, this definition has been broadly acceptance in general practice.

CMHS Definition of Individuals with Serious Emotional Disturbance:

- From birth to 18 years

- Who currently, or at any time during the past year have, or had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria of the Diagnostic & Statistical Manual for Manual Disorders, Vol. IV. (DSM IV)

AND

- This diagnosis resulted in functional impairment ***that substantially*** interferes (d) with, or limits, the child's role or functioning in family, school, or community activities.

AND

- These disorders *exclude* V codes, substance use, and developmental disorders, *unless* they co-occur with another diagnosable serious emotional disturbance.

Although this definition has provided some direction regarding identifying youth with SEBD, it did not standardize the methodology for how professionals shall evaluate the level of functional impairment. In many states, there has been the growing use of the Child and Adolescent Functional Assessment Scale (CAFAS) to provide consistency to the determination of level of functioning across a child's life domains. The CAFAS provides a methodology for assessing a child's behavior towards self and others as well as the functioning in the home, school, community and other life areas. (See Appendix C).

Within the population of children and youth with EBD, patterns frequently emerge in the type of issues and concerns that present to the school, mental health team and community. These patterns, as defined below, help guide the design of the mental health system and treatment interventions.

Multiple Child-Serving Agencies

Children and youth with SEBD often receive services from the mental health system as well as other child serving agencies. Often, the child welfare, juvenile justice and education systems provide mental health services in addition those provided by public or private mental health entities. It is estimated that 30 – 50% of children and youth with SEBD are served by more than one child-serving entity.

Nationally, the average length of stay of youth in juvenile detention centers is 11 days. However, this statistic increases to 35 to 40 days for youth with mental

health problems, and 60% of the youth who stayed in juvenile detention for more than 30 days are considered to have significant mental health problems. The Department of Justice reports that as many of 73% of youth in juvenile correction facilities have mental health needs.

Nationally, it is estimated that 11% of special education youth have emotional disturbance. These youth often receive services from both their home school and the public mental health agency.

It is estimated that as many as 70% of the children and youth in the child welfare system have mental health issues, with as many as 35% having serious emotional disturbance.

Given this high percentage of involvement in other child serving agencies, it is imperative that involved agencies coordinate the services and supports provided to these youth.

Youth with co-occurring disorders

The incidence of youth with SEBD who have more than one DSM IV diagnosis is estimated to be as high as 40%. This creates the need for clinicians and provider agencies to be knowledgeable of all childhood disorders and the impact that the disorders and treatment s may have on the whole child. When approaching the treatment planning process, mental health providers must be cognizant of the whole child's needs and not just isolate one specific treatment intervention.

It is estimated that 20-35% of youth receiving mental health services have both a mental health illness and a substance abuse problem. As many as half of all individuals that have a diagnosable mental health disorder are projected to develop a substance abuse problem at some point in their lives. Similar to co-occuring mental health issues, this creates a need for clinicians to be aware of diagnostic and treatment strategies for both mental health and substance abuse problems.

In addition, when approaching treatment planning there must be awareness of the cognitive functioning of the individual. Estimates are as high as 10-50% of youth with mild mental retardation (MMR) also have Axis I diagnosis for emotional and behavioral disorders. These youth with MMR are not severely mentally retarded, but rather they present with limitations in cognitive functioning that create unique challenges to treatment interventions.

SEBD Youth in Residential Treatment Programs

Nationally, it is projected that nearly half of children's mental health funding goes to the more restrictive residential programs. Nationally, only 8% of children treated for SEBD are served in residential treatment centers, and yet it accounts

for 25% of the national funding. In addition to the high cost of this service, the use of residential treatment centers present issues of separation from family and exposure to other maladaptive behaviors that must be dealt with in the treatment program. Finally, the treatment outcomes of youth in residential programs have not demonstrated long term sustainable results.

Because of these issues, children's mental health advocates and leaders began reviewing how these residential treatment programs were being used. In recent years, there has been a movement, toward serving only the most seriously emotionally disturbed youth in these programs and for a period of approximately 1month for intensive evaluation and stabilization. After this time period, the youth are moved to less restrictive community programs.

Support for Evidence Based Services

There is limited definitive evidence regarding which treatment interventions are most beneficial for children and youth. Although service research has been conducted in various university-based settings, there is not adequate research evaluating the application of these services in diverse community settings with wide variation in the population and clinician knowledge and competency. As our knowledge of effective services increases, there is the need for mental health systems to develop the availability of these services.

Support for Early Intervention Services

While it is typically recognized that early intervention programs and services are the most effective way to create long term change the lives of our young people, these services are the typically most difficult to sustain funding support. It is recognized that early identification and effective intervention will reduce costs in the long run and produce more positive outcomes for our society. However, during times of tight budget allocations, these programs are often some of the first to be cut. This is recognized as a national concern with federal attempts to prioritize early identification and services for youth with mental health challenges.

Transition to Adulthood

Given the challenges that youth with SEBD face when transitioning to adulthood, there is growing a movement for the mental health agencies to become more involved in support during this time in life. These young people require help in developing skills to live independently, locate employment, maintain work relationships and job performance, and manage other adult obligations. There is a need to begin working with youth and their support network on these issues as early as age 16, with supports often in place through 25 years. By supporting successful transition to adulthood, the mental health system can significantly impact the involved of the adult mental health system and adult corrections system. (National Technical Assistance Center, 2002).

Services for Children & Youth of Rural Communities

Across our country, the rural communities continue to face unique challenges in supporting children and youth with SEBD. Often times, there are limited number of clinicians, programs and supports available. These challenges require that these communities have the ability to flexibly plan for how to best meet the needs of their children and youth. This flexibility often includes additional funding to bring expertise from outside the community on a consultation basis, and funding to develop community programs to meet the needs of these youth.

Funding Issues

In our country, states are the primary source of funding for children's mental health services. Given the current economic challenges that states are facing, there are budget reductions and fiscal pressures that are causing them to take steps to reduce or curtail services. It is estimated that almost 75% percent of states are taking steps to reduce or contain children's mental health expenditures in FY '03. The maintenance of funding for children's mental health has become a critical issue for our country in the coming years. The President's Task Force on Mental Health is currently reviewing the issues of funding and service availability for children and youth.

Studies from many states, and the Surgeon General's Office, have shown that children and youth with SEBD, and their families, are best served through a coordinated array of community-based services and supports. Given the limited funding available for children's mental health, it is suggested that efforts be targeted at supporting these locally managed community-based services. If states continue to expend the majority of their funding toward the high cost residential programs, there will be limited support for the services needed by the majority of the children.

National Conclusions

Childhood emotional disturbance has a dramatic impact on the lives of millions of children and their families. Their individual and collective challenges dramatically affect our nation's schools and communities. The emotional disorders experienced by these children greatly affect their ability to become contributory members of our society. Given the impact to our society from both a social and economic perspective, it is clear that appropriate services, supports, and funding are critical for this population.

Efforts need to be made to across child serving agencies to serve children and youth in most effective and efficient manner possible. Too many of the youth are served by more than one entity. The time has come for states to come together with a unified approach for serving youth. Attention needs to be given to early

identification and intervention programs, as well as co-occurring treatment approaches. Particular focus needs to be given to those youth involved in the juvenile justice system.

Finally, there is tremendous need for the children's mental health agencies to be held accountable for achieving performance with measurable outcomes. There is a need to study those interventions and treatments that can demonstrate true changes in the lives of the children. Priority should be given to those services that demonstrate effectiveness with given populations.

Recently there has been much attention given to the need for mental health agencies to collect performance data, but because the data collection procedures vary and the analyses are limited, the information that has been used to guide program development may not have been as informative or relevant as intended. States need to prioritize strategies to effectively evaluate service delivery and outcomes.

A Decade of Growth in Hawaii

The 1990's were a decade of dramatic change and growth for Hawaii's children's mental health system. Somewhat spurred by lawsuits, but also by increasing community and family efforts, the Child & Adolescent Mental Health Division (CAMHD) has undergone dramatic transformation in serving the children, youth and family.

Civil Rights' Violations against Institutionalized Children: The DOJ Settlement

In 1991, the state settled a class action civil rights lawsuit with the Department of Justice (DOJ). The DOJ filed suit against the state for violations of civil rights at the individuals residing at Hawaii State Hospital (HSH). At that time, children were placed at HSH, and therefore, became part of that lawsuit.

As a result of efforts to comply with the DOJ Settlement Agreement, CAMHD moved all children and youth from HSH in1994. Children and youth in need of institutional residential care were contractually served by a private hospital, Kahi Mohala. In 1997, CAMHD expanded these contract services to include also Queens Hospital. These two programs are identified by DOJ as Child & Adolescent Residential Services (CARS).

Dramatic changes have taken place in those programs and in CAMHD's monitoring and management of these contracted services. In 1999, there were 68 children and youth in those programs with a waiting list of many more youth. Through the development of a clinical case management model of practice, and

a comprehensive array of community-based services, CAMHD has been able to reduce this census to 16 youth in these programs. The length of stay in these programs is now typically less than 60 days, whereas historically youth often stayed for more than a year. The focus of these programs has changed to stabilization and intensive intervention, enabling children and youth to be discharged to a community based program or home environment with supports.

The DOJ has offered many positive comments to the Federal Court identifying the gains in the CAMHD CARS programs. The DOJ has recently completed a site visit of the CARS programs, and is preparing a report for submission to court. CAMHD is hopeful that recognition will be given for the efforts of CAMHD and its contracted agencies.

When CAMHD is deemed to be in compliance of the requirements of the settlement agreement, it is expected that ongoing monitoring will be required to demonstrate the state's ability to sustain the current level of performance.

Educational Violations: The Felix Consent Decree

On May 4, 1993, the Governor, the Superintendent of Education, and the Director of Health (Defendants) were sued in Hawaii Federal District Court for failure to provide adequate mental health services to children and adolescents in need of these services in order to benefit from their educational programs. On March 8, 1994, the case was certified to be a class action suit on behalf of all children and adolescents between birth and age twenty with disabilities, who reside in Hawaii and who are eligible for, and in need of, educational and mental health services (Plaintiff Class), but not receiving these services.

CAMHD is an attached entity to this lawsuit as a result of HRS 321-174 that requires DOH to consult with schools in the provision of mental health services. It is because of this statutory obligation, that this education-based lawsuit involved the DOH.

On May 24, 1994, the Court filed an order concluding that the Defendants had failed to provide the services necessary to comply with the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1401). The Plaintiff Class and the State of Hawaii reached a settlement and jointly drafted a Consent Decree which sets forth the terms and conditions of the settlement. The Court approved the Consent Decree on October 25, 1994.

The Consent Decree provided that members of the Plaintiff Class shall receive a free and appropriate public education as required under IDEA and Section 504 of the Rehabilitation Act. And in addition, the State was to create a system of services, programs, and placements for the Plaintiff Class following the principles of the Child and Adolescent Service System Program (CASSP) to correct the systemic failure. The original CASSP principles, as outlined in *A System of Care for Severely*

Emotionally Disturbed Children and Youth, were modified slightly to reflect language preferences of Hawai`i's communities, but remain true to the original values and principles (Stroul & Friedman, 1986). These principles are identified in the CAMHD Mission, and as Appendix C.

Between 1994-2002, CAMHD focused efforts on developing a competent care coordination system that would provide for coordination of the array of services, developing service capacity and clinician competency, and monitoring and evaluating the system.

In September 2002, federal Judge David Alan Ezra recognized the accomplishments of the state and found the state to have substantially met the requirements of the consent decree. He did, however, offer concern about state's commitment to sustain these efforts. As a result of the courts concerns about sustainability, the Judge ordered continued oversight for a period of at least 18 months, with oversight continuing at the same level as presently in place.

Accordingly, CAMHD must demonstrate continuation of the monitoring and effective oversight in managing the children's mental health system.

Statewide School-Based Behavioral Health

Effective fall of 2000, the CAMHD and the Department of Education (DOE) moved to a school-based mental health model for services to Felix eligible youth. Each school provides the mental health assessments and school-based outpatient services that students need to benefit from their education program. If the school team needs access to more intensive mental health services, a CAMHD Mental Health Care Coordinator (MHCC) works with the school team to facilitate appropriate services. This coordinated relationship between the school system and the mental health system provides a system of care that has the school as a central access point for mental health services for educationally disabled youth. Through this interwoven relationship between DOE and DOH, a comprehensive array of mental health services is provided to all eligible youth.

Behavioral Health Services with Med-QUEST Plans

The Med-QUEST Division (MQD) the state's Medicaid agency, contracts with health plans to provide health services to the Medicaid eligible population. The health plans provide medically necessary mental health assessment and treatment services to children and youth.

Since 1994, the MQD and CAMHD have had an Memorandum of Agreement (MOA) outlining that CAMHD serves the state's Medicaid eligible SEBD youth. In 1999, the MOA was modified to include services to all Felix eligible served that are Medicaid eligible. In accordance with the MOA for SEBD youth, MQD identifies children and youth that are SEBD eligible, and at that time, the

child/youth is referred to CAMHD for intensive care coordination and access to the comprehensive array of community-based services. For the Felix eligible youth that are Medicaid eligible, MQD and CAMHD go through a reconciliation process to properly identify those youth, allowing for maximization of federal funding.

Today's Children's Mental Health System

Hawaii is a state of approximately 1.2 million people, including 330,000 youth ages zero to eighteen. The majority of the state's population is found on Oahu in Honolulu and it's surrounding areas. Using the prevalence estimates recommended by the Center for Mental Health Services, and set forth in the paper "Prevalence of Serious Emotional Disturbance in Children and Adolescents" (June 1996), it is estimated that as many as 29,700 Hawaii youth experience some level of emotional disturbance, with as many as 16,500 experiencing significant challenges in daily functioning.

The State of Hawaii provides public mental health services through the Department of Health (DOH), Department of Education, and the Department of Human Services (DHS) Med-QUEST Division. In the DOH, three divisions comprise the Behavioral Health Administration (BHA): Adult Mental Health Division (AMHD), Alcohol and Drug Abuse Division (ADAD), and the Child and Adolescent Mental Health Division (CAMHD). The Deputy Director for Behavioral Health, who reports to the Director of Health, oversees the BHA. The Director of Health is an appointed cabinet level position. In the Department of Human Services, MQD provides behavioral health services for the Medicaid eligible population through managed Medicaid services, known as the Quest Plans.

Statutory Authority

Hawaii Revised Statute 321-171 requires that the DOH "provide preventative, diagnostic, treatment and rehabilitative services for emotionally disturbed and mentally ill children and youth." All services are to be delivered at the earliest possible moment after the need is identified. All services are to be provided to children and youth between the ages of birth and seventeen. Within the DOH, services to children birth to 3 years are provided by the Early Intervention Section. CAMHD provides services to children and youth three through seventeen, unless their educational program extends the eligibility to age 20.

HRS 321-172 requires that CAMHD "coordinate the effective and efficient delivery of mental health services to children and youth, including services provided by private nonprofit agencies under contract to the department of health, and be responsible for the development and implementation of centralized and highly specialized programs for children and youth."

HRS 321-173 requires that community mental health centers provide a network of services based on the needs of the geographic region. It also requires that the community mental health teams cooperate with other local agencies in serving youth of that area.

HRS 321-174 requires that the community mental health teams cooperate with the local schools in identifying and referring for treatment, such children and youths in need of mental health services.

In accordance with the above statutes, CAMHD has developed a comprehensive vision and strategic plan to meet the needs of the children and youth needing mental health services.

CAMHD VISION

Hawaii will provide the necessary supports and services that will allow children, youth and families to lead fulfilling and productive lives. These services and supports will be provided in caring communities throughout the state. These services and supports will effectively and efficiently address the individualized needs of children/youth with emotional and behavioral challenges.

CAMHD MISSION

The mission of the Child & Adolescent Mental Health Division is to provide timely and effective mental health services to children and youth with emotional and behavioral challenges, and their families. These services shall be provided within a system of care that integrates Hawaii's Child & Adolescent Service System Program (CASSP) principles (as outlined below), evidence based services, and continuous monitoring efforts.

HAWAII CASSP PRINCIPLES

The Child & Adolescent Mental Health Division is committed to the principles as developed by the Hawaii Task Force in 1993, adapted from Stroul, B.A. and Friedman, R.M, 1986). (see Appendix A for full document)

Respect for Individual Rights
The rights of children will be protected and effective advocacy efforts for children will be promoted.

HAWAII CASSP PRINCIPLES (cont.)

Individualization
Services are child/youth and family centered and culturally sensitive, with the unique needs of the youth and family dictating the types and mix of services provided.

Early Intervention
Early identification of social, emotional, physical and educational needs will be promoted in order to enhance the likelihood of successful early interventions and lessen the need for more intensive and restrictive services.

Partnerships with Youth & Families
Families or surrogate families will be full participants in all aspects of the planning and delivery of services.
As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.

Family Strengthening
Family preservation and strengthening along with the promotion of physical and emotional well-being is a primary focus of the system of care.

Services which require the removal of a child from his/her home will be considered only when all other options have been exhausted, and services aimed at returning the child to his/her family or other permanent placement are an integral consideration at the time of removal.

Access to Comprehensive Array of Services
There will be access to a comprehensive array of services that addresses each child's unique needs.

Community Based Service Delivery
Service availability, management and decision-making rest at the community levels.

Least Restrictive Interventions
Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.

Coordination of Services
The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that each child can move throughout the system in accordance with his/her changing needs, regardless of points of entry.

Design of the Current System

The CAMHD provides mental health services through an integrated system with the Department of Education (DOE) and the Med-QUEST Division (MQD). Children and youth that have educational disabilities receive school level supports and services through the home school. The school provides assessment and diagnostic services whenever there is concern that there may be a disability impacting education. If indicated, the school then provides classroom strategies and specific mental health services.

Children and youth that are having emotional challenges that are not impacting their education, receive mental health services from the family private insurance or MQD provider. The MQD Health Plans provide medically necessary assessment and mental health treatment services.

CAMHD provides intensive mental health services, as defined in the array below, for children and youth that are referred by the home school or by MQD.

CAMHD is designed in a public private partnership with eight Family Guidance Centers (FGCs) and 21 provider agencies across the state. CAMHD has approximately 240 authorized positions allocated across organizational components, including the central administrative office and eight public FGCs.

The Division's FY 2002 expenditures were approximately $96 million, which shows stability from the previous year. The budget allocation for CAMHD represents a substantial increase from 1991-92, when the budget was approximately $15 million.

The CAMHD central administrative service consists of approximately 75 authorized positions and is divided into three offices: administrative services, clinical services, and performance management. The Division's Assistant Chief heads the Administrative Services Office. The staff in this office is responsible for budget, accounting, personnel, contract administration, planning, financial resources development and information management. The Clinical Services Office provides leadership of the clinical practice issues, training, specialty case consultation, utilization review, and resource management. The Performance Management Office provides the Division's monitoring and quality assurance functions. This office leads the FGC and provider monitoring activities, CAMHD Quality Assurance Staff, credentialing, licensing, and Grievance and Appeals Staff.

Four Family Guidance Centers are located on Oahu, and one each on Kauai, Maui and the Big Island. Each Family Guidance Center is headed by a Branch Chief, and is supported by a psychiatrist, section supervisors, a psychologist, quality assurance specialist, fiscal officer, and mental health care coordinators. Services provided by the centers include liaison with the schools, receipt of all referrals, registration of clients, care coordination, and intensive clinical case

management. The Family Court Liaison Branch (FCLB) provides non-educationally driven assessment and treatment services to youth at the Hawaii Youth Correctional Facility (HYCF) and the Detention Home (DH), and consultations to the Family Court.

The CAMHD procures intensive mental health services for approximately 1700 children and youth with SEBD. CAMHD also provides periodic specialized assessments for youth involved in the juvenile justice system. The services available are outlined below and are provided by approximately 21 agencies contracted by the state.

Service Trends

Of the 1700 children and youth, approximately 370 are placed out of the home for treatment in any given month. Although this percentage may appear high, it is important to recognize that CAMHD does not provide routine outpatient services. The school or MQD Health Plan provides these services. CAMHD only provides the intensive services for those youth with the most severe challenges. The average numbers of individuals served in therapeutic foster homes (TFH) are 140, group homes are 80, and community residential programs are 130. Other than the use of hospital based residential declining across the past year; use patterns haven't had significant changes.

CAMHD provides services in the least restrictive setting. In past 3 years, the number of children placed out of state has declined from 90 to 5. Children and youth placed in HBR declined from 68 to 16.

Services gaps for unserved youth have been minimal in the past year. Service mismatches occur when a child or youth is getting some services, but not the exact service or combination of services that is sought by the team. The typical service mismatch still impacting CAMHD is a delay in finding the right match for TFH placement. While CAMHD works to arrange the correct TFH, the youth may be served through other means. In this case, the youth is identified as having a "mismatch" of services.

Services Provided

The CAMHD service array includes crisis response services, intensive care coordination (known in other states as intensive clinical case management), intensive home and community based services, and out of home services. These services are defined below. In addition, there is flexible funding available to support informal community supports and programs that may be necessary to sustain a youth in the home community. In the case that CAMHD may need to complete a mental health assessment or provide direct outpatient services, the services of the FGC psychiatrist or psychologist may be used, or the FGC may procure the services off the state Purchase of Service (POS) treatment list.

Through its FCLB, CAMHD also provides mental health assessments and treatment services for youth at the Detention Home and Hawaii Youth Correctional Facility (HYCF).

Contractually, the array of services has been made available across the state, and efforts have been made to assure capacity within each community. However, due to limited need, higher cost, and other challenges, the resources continue to be limited in rural areas. Presently, there are emergency and crisis services, intensive in home, MST services, and therapeutic foster homes, in limited capacity, available in each community. At the present time, there are no community based residential programs on Kauai, Molokai, or Lanai. There are limited numbers of group homes in the rural communities as well. The services available through CAMHD contract provider agencies include the following.

Emergency Crisis Intervention Services

24-Hour Crisis Telephone Stabilization

Hot line serving all youth whose immediate health and safety may be in jeopardy due to a mental health issue. After receiving support, consultation and referral that dissipate the crisis situation, the youth's natural environment has the capacity to allow the youth to remain safely in the community.

Mobile Crisis Outreach

This service provides mobile assessment and stabilization services for youth in an active state of psychiatric crisis. Services are provided twenty-four (24) hours per day, seven (7) days per week and can occur in a variety of settings including the youth's home, local emergency facilities, and other related settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, and medical stability, and immediate crisis resolution and de-escalation if necessary.

Crisis Stabilization

This service offers short-term, acute residential interventions to youth experiencing mental health crises. This is a structured residential alternative to, or diversion from, Hospital-Based Residential Services. Crisis stabilization services are for youth who are not in need of acute inpatient care, but are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the youth.

Assessment and Diagnostic Services

Mental Health Assessment

Diagnostic and evaluation services involving a strengths-based approach to identify youth's needs in the context of school, family and community. These services include completion of initial assessments, tri-annual assessments, and initial supplementary mental health assessments as part of the DOE identification and eligibility process. Service components include written assessments, a feedback session, and MHTP suggestions.

Psychosexual Assessment

Specialized diagnostic and evaluation services involving a strengths-based approach to identify youths' needs in the specific context of sexually abusive behaviors. Service component includes provision of written assessments. These assessments should have been preceded by information gathering from existing sources and should not occur unless a comprehensive clinical assessment has been performed first. This assessment is designed to build on the clinical assessment through the use of specialized psychometric instruments designed to assess sexual attitudes and interests.

Intensive Day Stabilization

A service that provides stabilization of psychiatric impairments and maintains youth in the community or returns youth from a more restrictive environment to home/community. The focus of the program is to provide diagnostics and focused assessments, and the development of therapeutic and functional recommendations for improved treatment outcomes. The goals of service are clearly articulated. The initial service objectives and continuing care plan are established prior to admission through a comprehensive assessment of the youth to include: a severity-adjusted rating of each clinical issue (including frequency and duration of diagnosis) and strength. Treatment is time-limited, ambulatory and active, offering intensive, coordinated clinical services provided by a multi-disciplinary team. This service includes medication administration and a medication management plan. Level of care for each youth should include services available six (6) hours per day, seven (7) days a week, for up to ten (10) consecutive days. Daily availability of physician and nursing services are essential components of this service, since this is considered to be an alternative to Hospital-Based Residential Services.

Intensive Treatment Services

Care Coordination

The FGC Mental Health Care Coordinator provides this service. This service includes coordination and provision of services through active and assertive treatment approach. This service includes ongoing assessment of child and family status, monitoring of service delivery, and crisis support and resolution.

Intensive Home & Community Based Intervention

This service is a time limited approach that incorporates and supports evidence-based interventions. This service is designed to stabilize and preserve the child's functioning in the current living environment and to prevent the need for placement outside the home and/or home school (e.g., hospital-based or community -based residential). These services are delivered primarily to youth in their family's home with a family focus to: 1) facilitate, support, or newly implement the appropriate evidence-based intervention at a level of intensity that requires home-based contact with the child and family; 2) resolve any crises, evaluate their nature, and intervene to reduce likelihood of further incidence; 3) ensure and facilitate access to informal supports in the community as well as formal behavioral supports in the child's school (e.g. school-based behavioral health worker); and 4) increase capacity and strengths of the child and family so as to support and facilitate gains achieved through evidence-based approaches (e.g., transitioning maintenance of behavior, support plan, to individuals within the child's family or natural support network). Services are directed towards the mental health needs of the identified youth.

Multisystemic Therapy

Multisystemic Therapy (MST) is a time-limited, intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior in juvenile offenders. MST addresses the factors associated with delinquency across youths' key settings, or systems (e.g., family, peers, school, and neighborhood). Using the strengths of each system to foster positive change, MST promotes behavior change in the youths' natural environment.

Community-Based Treatment Services

Foster Homes with Therapeutic Services

Foster homes with therapeutic services are intensive community-based treatment services provided to youth with emotional disturbances in a home setting. Specialized therapeutic foster care supports incorporate evidence-based psychosocial treatment services. These homes provide a home environment through therapeutic parental supervision, guidance, and support for youth

capable of demonstrating growth in such a setting rather than in a more restrictive group residential setting. These youth are generally capable of attending their home school or an alternative community educational or vocational program. Such homes may also be beneficial for youths in transition from a restrictive placement as they offer a small family orientation. Specialized therapeutic foster care supports are appropriate for long-term treatment [six (6) to nine (9) months] and short-term crisis stabilization.

Therapeutic Group Homes

Therapeutic living program that provides twenty-four (24) hour care and integrated evidence-based treatment planning to address the behavioral, emotional and/or systemic issues which prevent the youth from taking part in family and/or community life. These homes are designed for those whose needs can best be met in a structured program of small group living in a community-based setting. The youth usually remain involved in community-based educational, recreational, and occupational activities. These homes typically provide services for three (3) to eight (8) youth per home. In this type of out-of-home residential care, youth are supervised and provided services by professional staff that have been recruited and trained to work with youth with emotional disturbance. This residential program is not required to be a secured setting.

Individualized High-Risk Group Homes

Individualized programs that are uniquely developed for particular youth whose needs cannot be met by the existing services offered. All other appropriate options have been exhausted and documented before accessing this level of service. Teams have met over a period of time to review and adjust interventions in place but little or no progress has been accomplished thus far. This service generally requires a one to one (1:1) for parts of the program day. Program is staff intensive in a well-structured, predictable environment with clearly established routine. This program serves a maximum of three (3) youth. The youth usually remain in community based educational, recreational, and occupational activities.

Community Based Residential Programs

Community-Based Residential programs provide twenty-four (24) hour care and integrated service planning that addresses the behavioral, emotional and/or family problems, which prevent the youth from taking part in family and/or community life. These programs are designed for those youth (includes late adolescents when the a group home is not sufficient) whose needs can best be met in a structured program of small group living in a community-based setting where youth can usually remain involved in community-based educational, recreational, and occupational services.

Community-Based Residential programs provide support and assistance to the youth and the family to enhance participation in group living and community activities, positive personal and interpersonal skills and behaviors and to meet the youth's developmental needs.

High Risk Community Based Residential (for sexual offending youth)

High Risk Community-Based Residential programs provide twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, that prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services.

High Risk Community-Based Residential programs provide support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth accept full responsibility and be accountable for sexually abusive or antisocial behavior without minimizing risk of reoffending or externalizing blame; 5) identify and change cognitive distortions or thinking errors that support or trigger offending ; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger reoffending and; 8) provide management of other behavioral or emotional problems.

Hospital Based Residential Services

Hospital based Residential (HBR) Services provide intensive in-patient treatment services to youth with severe emotional disturbance who require short-term hospitalization for the purposes of receiving intensive diagnostic, assessment and medication stabilization services. Services include multi-disciplinary assessment of the youth, skilled milieu of services by trained staff who are supervised by a licensed professional on a twenty-four-- (24) hour per day basis. Services are required to be staff secure at all times.

Flex Funding for Community Services/Supports

Flexible funding is available on an individualized basis to provide funds for clinically appropriate services and supports as outlined by the youth's team. These services and supports are used to augment mental health services being provided in accordance with the plan. These funds are accessed after community resources have been exhausted and after a plan has been developed to sustain the supports without ongoing need for this type of funding.

Respite

Respite services are available to provide temporary short-term relief to family members of children or youth with serious emotional or behavioral challenges. It is recognized that the family caregiver role can be personally rewarding, but it can also result in substantial emotional, physical, and financial hardship. Respite services allow children and youth to reside in their home communities by providing periodic supports to the family. Supports are available to families through means of minimal financial support and brief out of home placement.
Respite Homes

Mental health respite homes provide safe, short term and supportive environments for youth with emotional and/or behavioral disturbances. In addition these homes provide structured relief to the parent/caregiver(s) and families of these youths. These services support parent(s)/caregiver(s) in their efforts to continue caring for the youth in the home setting, thus reducing the risk of out of home placements at a higher level of care.

Services & Services to Youth involved in Juvenile Justice System

The Family Court Liaison Branch (FCLB) provides assessment and brief treatment services to youth in the Detention Home. In addition, there is a mental health center located on the grounds of the Hawaii Youth Corrections Facility (HYCF) that provides risk assessment, brief therapy services, and transition planning services to incarcerated youth with mental health needs. Finally, the FCLB provides assessments for judiciary as needed, for those youth not able to otherwise access assessment services.

Statewide Family Organization - Parent Partner Affiliations

CAMHD contracts with a statewide family organization (SFO) that offers training, support and guidance to families of children and youth with serious emotional disturbance. The SFO provides a parent partner for each community across the state. These parent partners provide training, outreach, and support to the families of children and youth with SEBD.

The parent partners are also members of the FGC management teams. On a statewide level, the Executive Directors of the SFO sit on CAMHD Management Team.

Services & Supports to HomelessYouth

CAMHD contracts for services for homeless youth using federal block grant monies. The purpose of this contract is to provide emotional and behavioral health services through outreach to homeless youth. Focus of these outreach services is developing trust with these youngsters so that they might be more willing to access the necessary services. These services include risk

assessments, counseling services, and assistance with living arrangements and vocational training.

Services & Supports to Transgender Youth

CAMHD contracts for services for transgender youth using federal block grant monies. The provider of these services offers outreach services and array of support services to this vulnerable population. Services to this population include risk assessments, educational programs regarding harm reduction, assistance with safe living arrangements and job skills training.

Early Intervention Services

Through the use of federal block grant funding, CAMHD has entered into an Memorandum of Agreement (MOA) with the Department's Early Intervention Section (EIS) to provide additional funding to support personnel and services to children ages 3-5 years and their families. The additional personnel to EIS allows for training families, child care providers and preschool staff on identifying and supporting children with emotional and behavioral challenges.

Supports for Transition to Adulthood

Through the use of federal block grant funding, CAMHD provides funding to the UH School of Social Work to support efforts to educate and train MHCCs and providers in assisting youth in the transition to adulthood. In addition, CAMHD maintains a Transition Specialist to provide leadership to the Division's effort to support youth in a successful transition.

Statutory Obligations to Planning

Statutory References

In accordance with HRS 321-175, CAMHD is required to "develop and present to the governor and the legislature, as well as release for public inspection and comment, a current statewide children's mental health services plan," to include a number of focus areas. These areas include identification of youth in need of and receiving services, description of services, identification of providers, criteria for receiving services, and an implementation plan.

In accordance with HRS 321-176, every two years the department "shall submit to the legislature and the governor, a report setting forth…a detailed analysis of the progress made toward fulfilling the statewide plan…."

Development

This strategic plan was developed based upon input received from families, communities, provider agencies, state departments and members of the legislature. Upon completion of statewide community meetings, the CAMHD Management Team, with family and community participation, integrated input and ideas in this plan. The plan was then put forth in a public hearing process and presented to the governor and the legislature, per statute requirement.

Reviews & Updates

This plan addresses CAMHD activities for calendar year 2003 through fiscal year 2006. Quarterly review of progress will occur with the CAMHD Management Team. Annual progress will be presented to all stakeholder groups. Biannual reports will be provided to the legislature to report on progress of implementation.

Trends & Assumptions in Planning

In the development of this plan, there were several assumptions that were made about the future of Hawaii's children's mental health system. The effectiveness of this plan is dependent upon the accuracy of these assumptions.

The assumptions include that the population will be stable. CAMHD is not projecting a dramatic increase or decrease in total population served. Although it is recognized that there will be routine admissions and discharges, there is not expected to be any drastic difference in the bottom line number of youth served over this time period. Also, it is assumed that the resource allocation will be stable. CAMHD does not project significant changes in personnel or budget allocation over this period. It is expected that CAMHD and its provider agencies must be accountable for the expenditure of state and federal funds, and must provide sufficient justification of funding over this period. However, based upon justification of need, CAMHD expects current level of personnel and fiscal resources to be maintained.

Understanding CAMHD Plans

When reviewing the next four years of CAMHD initiatives, this plan must be reviewed along with the *State's Sustainability Plan* for the FCD. In addition, the following plans, currently in process of development, may provide additional details as they are completed. These include a juvenile justice and mental health strategic plan, youth with sexualized behaviors master plan and CAMHD early identification strategic plan

SECTION II

STRATEGIC GOALS & OBJECTIVES

Goals and Performance Measures

The Child and Adolescent Mental Health Division (CAMHD) maintains a core belief that in order to achieve positive outcomes for Hawaii's children and youth with mental health needs, the strategic planning to address those needs must occur statewide, and at the community level, with broad goals and specific indicators of the health, safety, and well-being of children and youth. CAMHD also acknowledges as a priority, the belief that the system has to be accountable, through the use of performance measures, to the persons it serves, including children/youth, families and other related stakeholders. These strategic goals, implementation strategies, and objectives were developed with the input of people from varying backgrounds, disciplines, and organizations, are broad enough to impact the children's mental health system statewide, but also small enough to be effectively managed.

Goal 1: CAMHD will facilitate and support the shared ownership of the CAMHD vision, mission, initiatives, and achieved outcomes.

1.1 *Performance Target #1: All child-serving entities have an understanding and appreciation of each other's roles and responsibilities in addition to their own:*

1.1.1a Year 1 Implementation Strategies:
One of the primary barriers to a system of care in which there is shared ownership of the mental health aspect of a child/youth's life, is a lack of understanding, especially amongst staff at the community/district level, of the roles and responsibilities of each child-serving entity and how a child's school, home environment, and socio-economic status, can impact that child/youth's mental health and positive outcomes.

- The CAMHD Chief and FGC Branch Chiefs will engage with other child-serving agencies in the development and implementation of a statewide leadership framework at the community and local level, through visits and discussions with community stakeholders throughout the state.
- CAMHD's internal management values and practices will be cultivated and improved by the CAMHD Chief, CAMHD Managers/Supervisors, and FGC Branch Chiefs, through facilitation and implementation of an appropriate supervisory infrastructure, regular opportunities for feedback on the work environment, internal training and mentoring initiatives, and a commitment from CAMHD managers, to fully integrate these management values into the everyday operations within CAMHD.

1.1.1b Year 1 Internal Objectives:

- The establishment of a statewide leadership framework with commitment from leadership of the state's child-serving entities, will foster a consistent

understanding across these entities of how each functions within the state's system of care and will also provide a framework within which, a cohesive and collaborative approach to the care of Hawaii's children and youth can be effected.

- The focus on CAMHD's internal management values and practices in this first year, represents the first step towards an environment where all CAMHD employees, at all levels, and in all communities, embrace equal ownership for the system's accomplishments, challenges, and shortcomings. CAMHD managers and supervisors will implement a consistently applied supervisory infrastructure that will allow employees to grow and learn as they work, receive positive feedback when successes occur, and receive constructive criticism and added support when necessary.

1.1.2a Year 2 Implementation Strategies:

Accountability of a system is inherently based upon the notion that it is possible to combine all activities, initiatives, focus areas, organizational and leadership structures, and resources, to bring about shared outcomes and results, and that therefore, everyone who has taken part in the process, can equally own that system and its accomplishments. To this end, all child-serving entities, community organizations, and families, work towards the same overarching goal, the building of a system of care that allows children and youth to grow into healthy, successful and productive adults.

- CAMHD's Research and Evaluation Specialist and FGC Branch Chiefs, along with Hawaii Families As Allies (HFAA)(Hawaii's Statewide Family Organization), and the members of the Leadership Framework developed in Year 1, will work to agree upon joint outcome measures with consideration of respective existing outcome measures.
- The Leadership Framework, FGC Branch Chiefs, and HFAA, will work first at the state/executive level, to establish baseline protocol for resolving inter-agency disputes, and then will work within each community, to modify those protocol to develop protocols that are sensitive to the distinctive environment and unique cultural characteristics of Hawaii's various communities.

1.1.2b Year 2 Internal Objectives:

- Joint outcome measures will be agreed upon by all Hawaii child-serving entities leading to statewide accountability and shared ownership of the achievements of the children's mental health system.
- Protocol for resolving inter-agency disputes will be developed and implemented at the state and local/community level

1.1.3a Years 3 and 4 Implementation Strategies:

- Added focus on core management values and practices will result in high quality work for employees. CAMHD will invite all stakeholders to participate in presentations regarding improvements in CAMHD management values and practices.

- In order to sustain the system's improvement in this area, training and mentoring at the community/local level, monitoring of processes and outcomes, and revisions of developed tools, protocols and measures will occur as necessary.

1.1.3b Years 3 and 4 Internal Objectives:

- Joint performance presentations will have been conducted in strategically located areas across the state to ensure the widest dissemination of the information possible.
- Training and mentoring will be provided.
- Consistent monitoring by the Leadership Framework, which includes the CAMHD, will be conducted.
- All tools, protocol, and joint outcome measures will be current.

1.2 *Performance Target #2: There will be adequate resources available for all child-serving entities in order to meet their statutory mandates and their obligation to Hawaii's children and youth*.

1.2.1a Year 1 Implementation Strategies:

Shared ownership and equal accountability are challenged by limited resources. When an agency is struggling with lack of resources, what services are provided and the manner in which they are provided, become territorial in nature, and the danger then becomes funding driving services instead of how it should be, services driving funding.

- In this first year, CAMHD will work to implement the recently approved CAMHD State Plan Amendment (QUEST funding) that includes a commitment to Evidence-Based services.
- CAMHD will look to update its own statutes and will support all child-serving entities in updating their statutes. Clarity in statutory mandates should bring clarity to what services and legislative appropriations are appropriate for which child-serving entities.
- CAMHD will work to maximize all federal grant and other funding opportunities through working with other agencies to get approved, the creation of full-time grant writer positions within each agency and also conducting overall training and education on researching grant opportunities and grant writing skills.
- In this first year and ongoing, CAMHD will continue to make a concerted effort to integrate evidence-based services into the system of care. It is believed that by making these services available statewide and having the

ability to evaluate and implement them, costs will be stabilize as children and youth receive appropriate services. It is also expected that the corresponding treatment success will lead to a decrease in length of stay in the system and a decrease in the utilization of more restrictive levels of care.

1.2.1b Year 1 Internal Objectives:

- Increase in the amount of QUEST reimbursements received to offset the overall need for state general funds.
- Statutory updates have begun.
- Increase in the amount of federal funds received through the successful hiring of a full time grant writer and/or successful training and education on how to research grant opportunities and apply for those opportunities.
- Evidence-Based services are available statewide, can be evaluated, and implementation and evaluation are sustainable.

1.2.2a Year 2 Implementation Strategies:

- The CAMHD will support the completion of statutory updates for all child-serving entities in the state.
- Maximization of federal grant and other reimbursement opportunities will continue to occur.
- The Evidence Based Services (EBS) Committee and its Chair will continue to update and keep current our understanding of what services are empirically supported.

1.2.2b Year 2 Internal Objectives:

- All statutes will be updated.
- Increase in the percentage of overall resources available to CAMHD that are obtained through federal grant and similar federal funding/reimbursement opportunities.
- The integration of evidence-based services continues, and the system's understanding of what services are evidence-based, is current and continues to be revised according to current research.

1.2.3a Years 3 and 4 Implementation Strategies:

All necessary supports should be in place for the maximization of federal funding/reimbursement opportunities. Implementation strategies should be long-term.

- Maximization of federal grant and other reimbursement opportunities will continue to occur.
- The integration of evidence-based services into the system of care will also continue as the EBS Committee and its Chair continue to update our understanding of what services are empirically supported.

1.2.3b Years 3 and 4 Internal Objectives:

- Increase in resources available through federal grant and similar federal funding/reimbursement opportunities.
- The integration of evidence-based services continues, and the system's understanding of what services are evidence-based, is current and continues to be revised according to current research.

1.3 *Performance Target #3: Improvement in the active engagement of, and communication with, families and community organizations invested in the system of care.*

1.3.1a Year 1 Implementation Strategies:

In order for the CAMHD to be successful in implementing its vision and mission, that vision and mission needs to not only be CAMHD's, but must also be owned by the lives of the people CAMHD's services affect. Specifically the children/youth and families served by the system. Families and community organizations must feel that they are a part of the process, and that the state is working *with* them, and not leading them. The achievements of the system as well as its shortcomings, need to be personally experienced, because this indicates personal accountability which can drive the system forward in a much stronger and more stable fashion only state/organizational accountability (Vermont Communities Count, September 1999).

- Provide each family entering into and already in the system, an informational packet and orientation on the role of HFAA parent partners, who they are and what services they can provide. Also included in the packet will be a Community Children's Council (CCC) flyer. The CAMHD contracts with HFAA for their parent partners to be located within each Family Guidance Center, as a resource for families should they want additional assistance with navigating the system, addressing concerns, or just want the support of someone who understands how it is to be a parent of a child/youth with a serious emotional disturbance.
- MHCCs shall consistently include informal, as well as formal, contacts in their engagement of families.
- CAMHD and HFAA will focus on increasing public awareness of the system's accomplishments through newsletters, television ads/public service announcements, and the public thanking of those who have helped in the process. Positive messages are key to gaining support for and shared ownership of the system and its accomplishments.

1.3.1b Year 1 Internal Objectives:

- All new and current families are given the information on HFAA Parent Partner services, and there is a corresponding increase in referrals to and utilization of Parent Partners.

- There is an increase in family satisfaction and true partnership in the process, as measured by revised Family Satisfaction Surveys.

1.3.2a Years 2, 3 and 4 Implementation Strategies:

- The continued efforts to increase public awareness of the system's accomplishments through newspapers, television ads/public service announcements, and public thanking of those who have helped in the process.
- CAMHD will nurture an environment where families and community stakeholders are actively and fully engaged in the process as partners, and that there is shared ownership amongst CAMHD families and community stakeholders

1.3.2b Years 2, 3 and 4 Internal Objectives:

- Increase in public newsletters/articles, ads, and public service announcements (PSAs).
- Increased family satisfaction as measured by the Family Satisfaction Survey

1.4 *Performance Target #4: Increased collaboration with Hawaii's university and community college institutions in training students in CASSP principles, EBS, and an evaluative manner of thinking.*

1.4.1a Year 1 Implementation Strategies:
Part of CAMHD's vision is the use of evidence-based services to guide treatment decisions. FGC staff and contracted providers will understand the relevance and use of EBS and must have expertise in this area, which will be supported and sustained by the Practice Development Section of CAMHD.

- The first step towards this performance target is to map out where the children's mental health labor force comes from and out of which disciplines.
- Once the mapping is complete, the CAMHD Practice Development Section will facilitate meetings/discussions with university and community college educators to partner on how to incorporate these values/practices into their curricula to help meet the educational needs of those institutions.
- These same CAMHD staff will develop mini-modules that can be included in the university and college curricula and will also offer to guest lecture in classrooms.

1.4.1b Year 1 Internal Objectives:

- Mapping of the children's mental health labor force is completed.
- At least 2 meetings have been held between identified CAMHD staff and university and community college educators.
- Mini-modules covering different practice areas are developed.

- Offers to guest lecture are made.

1.4.2a Years 2, 3 and 4 Implementation Strategies:
After the first year, the mapping will have been completed and the initial meetings between CAMHD staff and university and community college educators will have occurred. Moving past the first year, the continuing implementation strategies for the remaining years of the plan are:

- Continue to offer to guest lecture in classrooms.
- Continued collaboration to ensure that mini-modules of various evidence-based services are updated as necessary.

1.4.2b Years 2, 3 and 4 Internal Objectives:

- Pursuant to guest lectures, current mini-modules, and the overall infusion of evidence-based services curricula into the university and community college classrooms, the children's mental health workforce including both FGC staff and provider agencies, will have a sufficient understanding, knowledge and use of EBS to best serve children and youth.

***Goal 2*:** The CAMHD and its providers will consistently adhere to the Hawaii CASSP principles (see Appendix A).

2.1 *Performance Target #1: Maintain and improve the community-based, accessible system of care through which families are guided by knowledgeable and experienced veteran staff.*

2.1.1a Year 1 Implementation Strategies:
The primary barrier to having a system that is committed to the Hawaii CASSP principles is the lack of understanding around what exactly those principles are, and how to utilize them to guide decisions once people know what they are.

- Acknowledging that *all* CAMHD staff must also know and understand the populations served within the context of CASSP principles, they will be trained and provided with teaching tools including examples of populations served and the application of CASSP.
- The first six months of this year will be to educate, train and inform CAMHD stakeholders and families to understand the populations served by CAMHD and the context of CASSP.
- To address the need for consistent and accessible information on the resources available in each community, the FGC Branch Chiefs, CAMHD Managers, and HFAA will work on researching catalogues of formal and informal resources/supports currently available in the communities and through partner agencies/entities.
- The CAMHD Research and Evaluation Specialist will work with HFAA to collect information on consumer satisfaction on the system, inclusive of CAMHD, regarding the implementation of CASSP principles.

- Continued integration of CASSP principles into supervision of care coordination.
- Strategic Plan will be developed to address full continuum of mental health services for youth involved in the juvenile justice system, inclusive of expanding the leadership role of the Family Court Liaison Branch.
- Coordinate the review and revision of the state's Juvenile Sex Offender (JSO) Master Plan.

2.1.1b Year 1 Internal Objectives:

- 85% of CAMHD staff will have received the information on CAMHD populations served and CASSP principles and trained in those areas. Attendance at these trainings will be documented 100% of the time.
- At *every* FGC community presentation, CAMHD stakeholders and families will be presented with and trained on CAMHD's target populations and the context of CASSP as it relates to their children/youth.
- Resource catalogues will be researched and hard copies of catalogues will be made available in each FGC, for each Parent Partner, and for HFAA.
- Data on consumer satisfaction with CAMHD's compliance with Hawaii's CASSP principles will be collected quarterly and an annual report will be made available to the public.
- Strategic Plan to address youth involved with the juvenile justice system is developed.
- Review and revision completed.

2.1.2a Year 2 Implementation Strategies:
In addition to the implementation strategies from Year 1, in Year 2 the system should be at a place where it can also focus on the following:

- Expand HFAA/Parent Partner role at each FGC and across stakeholder lines to guide families. This expansion will help families to maximize natural supports/resources or to facilitate access to formal services as needed, that are available in the community
- Develop a *statewide* resource catalogue that is broken down by geographic area.

2.1.2b Year 2 Internal Objectives:

- At *every* FGC community presentation, CAMHD stakeholders and families will be presented with and trained on CAMHD's target populations and the context of CASSP as it relates to their children/youth. They will know and understand what kind of system CAMHD should be helping to foster.
- Resource catalogues will be researched and hard copies of catalogues will be made available in each FGC, for each Parent Partner, and for HFAA.

- 90% of CAMHD staff will have received the information and been trained on populations and context of CASSP. Attendance at these trainings will be documented 100% of the time.
- Data on consumer satisfaction with CAMHD's compliance with Hawaii's CASSP principles will be collected quarterly and an annual report will be made available to the public.
- Strategic Plan to address youth involved with the juvenile justice system is implemented.
- 75% of Parent Partner positions filled, and 100% of families will be made aware of the availability of their Parent Partner at intake.
- By the end of Year 2, the development of a statewide resource catalogue by geographic area will be 50% completed.

2.1.3a Year 3 Implementation Strategies:

- In Year 3, *all* CAMHD staff will continue to be trained on the CAMHD populations served and the context of CASSP within the system of care.
- The CAMHD Research and Evaluation Specialist will continue working with HFAA to collect information on consumer satisfaction with how CAMHD and other stakeholders are applying Hawaii's CASSP principles.
- Continued implementation of the Strategic Plan to address the full continuum of mental health services for youth involved in the juvenile justice system, inclusive of expanding the leadership role of the Family Court Liaison Branch.
- The expansion of the HFAA/Parent Partner role at each FGC and across stakeholder lines to guide families will continue.
- Complete the development of a *statewide* resource catalogue that is broken down by geographic area.
- Implement the developed PP/FGC team to maximize natural supports/resources and/or facilitate access to formal services as needed.

2.1.3b Year 3 Internal Objectives:

We should begin to see a system that is accessible to families, with knowledge and experienced veteran staff, stakeholders and Parent Partners to guide them through the process. We should begin to see consistency in the application of Hawaii's CASSP principles across the state and in all treatment/service settings.

- 90% of CAMHD staff will have received the information on CAMHD population served and CASSP principles and been trained on populations and context of CASSP. Attendance at these trainings will be documented 100% of the time.
- Data on consumer satisfaction with CAMHD's compliance with Hawaii's CASSP principles will be collected quarterly and an annual report will be made available to the public.
- Strategic Plan to address youth involved with the juvenile justice system is implemented.

- The expansion of the HFAA/Parent Partner role at each FGC will result in 95% of PP positions filled, 85% of families have contact with a PP, and 75% of families have joint PP and MHCC contact.
- By the end of Year 3, the development of a statewide resource catalogue by geographic area will be 100% completed.
- As a result of the implementation of the PP/FGC team concept, by the end of Year 3 there should be a 90% increase in the use of natural supports as evidenced in CSP audits, and 85% of CAMHD children/youth should be served in their home settings.

2.1.4a Year 4 Implementation Strategies:
Performance Target #1 should be accomplished and the year should focus on the sustainability of achieving this target through the continuation of the following:

- In light of the inevitable staff turnover, *all* CAMHD staff will continue to be trained on the CAMHD populations served and the context of CASSP within the system of care.
- The CAMHD Research and Evaluation Specialist will continue working with HFAA to collect information on consumer satisfaction with how CAMHD and other stakeholders are applying Hawaii's CASSP principles.
- Implement the developed PP/FGC team to maximize natural supports/resources and/or facilitate access to formal services as needed.
- Continued implementation of the Strategic Plan to address the full continuum of mental health services for youth involved in the juvenile justice system, inclusive of expanding the leadership role of the Family Court Liaison Branch.

2.1.4b Year 4 Internal Objectives:

- 90% of CAMHD staff will have received the information on CAMHD population served and CASSP principles and been trained on populations and context of CASSP. Attendance at these trainings will be documented 100% of the time.
- Data on consumer satisfaction with CAMHD's compliance with Hawaii's CASSP principles will be collected quarterly and an annual report will be made available to the public.
- As a result of the implementation of the PP/FGC team concept, by the end of Year 4 the 90% increase in the use of natural supports as evidenced in CSP audits, and the 85% of CAMHD children/youth being served in their home settings accomplished by the end of Year 3, should remain consistent and should not decrease.
- Strategic Plan to address youth involved with the juvenile justice system is implemented.

2.2 *Performance Target #2: Ongoing education and public relations effort to broaden and improve attitudes, understanding and acceptance of families of children/youth with mental health needs.*

2.2.1a Year 1 Implementation Strategies:

Part of the effort to adhere to Hawaii's CASSP principles must include working with families to engage in public education and public relations as a way to de-stigmatize mental health disorders/disabilities. CASSP requires the system of care to be child and family-centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided. One concern that is repeated throughout the state, is the need to de-stigmatize mental disorders so that identification of a child/youth as being in need of mental health services does not further alienate that child/youth and his/her family from being full participants in the community and in the treatment planning process.

- In Year 1 HFAA along with CAMHD staff will research existing CASSP related materials and literature that are family friendly.
- The first year will also see the development and distribution of family/public friendly literature, which includes behavioral and functional examples of each CASSP principle, through the creation of family/community focus groups.
- CAMHD will work with other child-serving entities to integrate their logos on the Hawaii CASSP principle bookmarks that are distributed at each FGC.
- A newsletter will be developed highlighting family success stories as a method of positive public relations. FGC staff and HFAA will be partners in training of the community on de-stigmatizing children and youth with mental health needs, CASSP and related topics.

2.2.1b Year 1 Internal Objectives:

- A comprehensive list of CASSP-related materials that are family-friendly is developed and made available.
- New family-friendly brochures/literature that include behavioral/functional examples for each CASSP principle are developed with a minimum of one community focus group input per FGC. Also within the first year, the brochure/literature will be printed and 90% distribution to all individuals listed in the distribution plan will be completed.
- Logos of participating child-serving entities are integrated on the brochure and there is a distribution plan.
- The newsletter highlighting family success stories is published quarterly with an established distribution plan.
- 1 co-training is scheduled for each FGC with flyers advertising the training for each FGC; and the training curriculum and agendas for each topic will be developed.

2.2.2a Year 2 Implementation Strategies:

- Co-trainings with FGC staff and HFAA on de-stigmatizing children's mental health, CASSP and related topics will continue to occur.
- Continued distribution of family/public friendly literature that includes behavioral/functional examples for each CASSP principle.

- Conduct self-assessment of attitudes of FGC staff, partners and community members towards families of children/youth with mental health needs.
- Implement a research study on the results of the self-assessment.

2.2.2b Year 2 Internal Objectives:

- 2 co-training scheduled and conducted by each FGC with flyers advertising the trainings.
- The brochure/literature will be distributed to 100% of the individuals listed in the distribution plan.
- The tool for the self-assessment will be developed and the self-assessment will be conducted with 85% of FGC staff, and with 2 key partners and one community group per FGC.

2.2.3a Years 3 and 4 Implementation Strategies:

We should begin to see an improvement in the acceptance, by all persons, of families of children/youth with mental health needs. In order to sustain the gains made, the following strategies need to continue to occur:

- Co-training with FGC staff and HFAA on de-stigmatizing children's mental health, CASSP and related topics.
- Distribution of family/public friendly literature which includes behavioral/functional examples for each CASSP principle.

2.2.3b Years 3 and 4 Internal Objectives:

- 2 co-training scheduled and conducted by each FGC with flyers advertising the trainings.
- The brochure/literature will be distributed to 100% of the individuals listed in the distribution plan.

2.3 *Performance Target #3: Increase broader community involvement and development of resources to support children and youth and their families.*

2.3.1a Year 1 Implementation Strategies:

Pursuant to Hawaii's CASSP principles, families/surrogate families and children as they reach maturity, shall be full participants in all aspects of the planning and delivery of services. CAMHD acknowledges the need to increase community and family/youth engagement in these areas so that the system of care is accessible, meets the child/youth's needs, and is sustainable.

- Training and mentoring will be provided to all CAMHD staff to partner with HFAA to promote the CSP and strengths-based planning model.
- Engagement of families will continue to be a priority, and targeted training will be ongoing.
- All CAMHD staff and HFAA will also work to strongly support and promote youth participation in the planning process.
- FGC Branch Chiefs will begin to make a concerted effort to participate in community-based organizations, not necessarily only those involved with

mental health issues. As the system begins to move forward, CAMHD recognizes that in order for the system to sustain itself in each community, the mental health aspect of a child/youth's life needs to be integrated with the supports and resources available within his/her community. Efforts at integration will also help to bring the community into the system so that they can both understand and provide assistance in supporting these children/youth in their home environments.

- Begin to develop peer education/mentoring/tutoring program.
- Routine review of service gap reports with particular attention to availability of mental health services in rural communities, with development of services after a gap is identified.
- Development of a plan to include consultation and technical assistance for pre-schools and other early-childhood programs.
- Continue use of Block Grant funding to support services to homeless and transgender youth, and for early-intervention services.

2.3.1b Year 1 Internal Objectives:

- CSP reviews result in 85% compliance with quality indicators.
- 80% of CAMHD youth participating in the CSP process statewide will be satisfied with the services they are receiving (as measured by the Youth Satisfaction Survey to be developed and administered by HFAA).
- All relevant local community organizations have been identified, and FGC Branch Chiefs have offered to present to 85% of the identified groups.
- Development of the peer education/mentoring/tutoring program begins.
- 85% of children/youth residing in rural communities will be served without experiencing gaps in service.
- Plan for consultation and technical assistance for pre-schools and other early-childhood programs is completed.
- 85% of Block Grant performance measures will be achieved.

2.3.2a Year 2 Implementation Strategies:

- All CAMHD staff and HFAA will continue to work to promote the CSP and strengths-based planning model through training and mentoring.
- All CAMHD staff and HFAA will also continue to work to strongly support and promote youth participation in the planning process.
- FGC Branch Chiefs will continue to participate in community-based organizations, not necessarily only those involved with mental health issues.
- In developing peer education/mentoring/tutoring program, each FGC will develop a program in partnership with a community organization and the resulting MOA and program description will address the recruitment of teens as peer tutors/mentors.
- CAMHD will support local naturally occurring community-based after school/weekend programs that will assist youth in transitioning to adulthood. The focus will be on self-determination, independent living skills, work readiness and pre-vocational skills.

- Routine review of service gap reports with particular attention to availability of mental health services in rural communities, with development of services after a gap is identified.
- Implementation of the plan for consultation and technical assistance for pre-schools and other early-childhood programs.
- Continue use of Block Grant funding to support services to homeless and transgender youth, and for early-intervention services.

2.3.2b Year 2 Internal Objectives:

- CSP reviews result in 85% compliance with quality indicators.
- 85% of CAMHD youth participating in the CSP process statewide are satisfied with the services they are receiving (as measured by the Youth Satisfaction Survey to be developed and administered by HFAA).
- FGC Branch Chiefs have presented to 85% of the identified groups.
- Each FGC has developed a program in partnership with a community organization that addresses the recruitment of teens as peer tutors/mentors and MOAs have been drafted and signed.
- Each FGC has an MOA with 2 community organizations to support local naturally occurring community-based after school/weekend programs.
- 85% of children/youth residing in rural communities will be served without experiencing gaps in service.
- Plan for consultation and technical assistance for pre-schools and other early-childhood programs is implemented.
- 85% of Block Grant performance measures will be achieved.

2.3.3a Years 3 and 4 Implementation Strategies:

In addition to the 5 strategies identified in Year 2, the following 2 strategies are designed to review and follow-up on 2 of those strategies:

- Conduct demonstration program and follow-up study of youth in local naturally occurring community-based programs developed in Year 2.
- Develop an implementation plan for a “Kids Helping Kids” youth warm line. Peer mentoring and support is key to the success of children/youth in the system. A youth warm line would help not only those accessing the warm line, but also those youth participating in the program, gain a sense of independence as well as empower them to see that they can affect their own lives in a positive manner by becoming fully involved in the process.
- Routine review of service gap reports with particular attention to availability of mental health services in rural communities, with development of services after a gap is identified.
- Implementation of the plan for consultation and technical assistance for pre-schools and other early-childhood programs.
- Continue use of Block Grant funding to support services to homeless and transgender youth, and for early-intervention services.

2.3.3b Years 3 and 4 Internal Objectives:

- CSP reviews result in 85% compliance with quality indicators.
- 80% of CAMHD youth participating in the CSP process statewide are satisfied with the services they are receiving (as measured by the Youth Satisfaction Survey to be developed and administered by HFAA).
- FGC Branch Chiefs have presented to 85% of the identified groups.
- Each FGC has developed a program in partnership with a community organization that addresses the recruitment of teens as peer tutors/mentors and MOAs have been drafted and signed.
- Each FGC has an MOA with 2 community organizations to support local naturally occurring community-based after school/weekend programs.
- Data collected quarterly, regarding the # and % of youth employed or in higher education/training programs post-discharge.
- An implementation plan for the youth warm line is developed (Year 3) and staff and volunteers are recruited and trained and the phone line is made available and running (Year 4).
- 85% of children/youth residing in rural communities will be served without experiencing gaps in service.
- Plan for consultation and technical assistance for pre-schools and other early-childhood programs is implemented.
- 85% of Block Grant performance measures will be achieved.

Goal 3: CAMHD and its provider agencies will consistently apply the current knowledge of evidence-based services in the development of individualized plans. The design of the mental health system will facilitate the application of these services.

3.1 *Performance Target #1: Achieve the widespread availability of evidence-based services*

3.1.1a Year 1 Implementation Strategies:

The use of evidence-based services to treat children and youth with mental health needs has been acknowledged nationwide, as having a positive impact on the outcomes for those children/youth. When evidence-based services are not identifiable, best practices will be used. This first performance target focuses on the training phase of creating a system that is evidence-based

- Conduct training for CAMHD providers in evidence-based services as identified by CAMHD and the EBS Committee. The EBS Committee includes CAMHD clinical staff, family, DOE, providers, DHS, Family Court, and UH.
- Develop high quality training curricula and fact sheets regarding evidence-based services and best practices.
- Provide training in evidence-based decision making for FGC staff and prepare them for stakeholder meetings to discuss evidence-based

services and principles. If CAMHD expects its providers to be proficient in the use of evidence-based services, the FGC staff must also be proficient in this area so that when they facilitate discussion within the IEP or treatment team, they are able to help make decisions that are rooted in services that are evidence-based.
- Assure monitoring protocols include evidence-based services and CASSP.

3.1.1b Year 1 Internal Objectives:
- Evidence-based training curricula and fact sheets will be available.
- 85% of CAMHD providers and FCG staff will receive training in relevant evidence-based services.
- FGC leadership will be trained and prepared to facilitate stakeholder meetings to discuss and clarify evidence-based decision-making.
- 50% of MHCCs will be able to serve as leaders in regular practice discussions regarding evidence-based decision-making.
- Monitoring protocols include evidence-based services and CASSP.

3.1.2a Year 2 Implementation Strategies:
In Year 2 CAMHD will continue to conduct trainings for CAMHD providers in evidence-based services and will continue to provide training in evidence-based decision-making for FGC MHCCs. In order to be able to monitor providers and FGC staff post-training, the following strategies will be implemented in Year 2:
- Develop care coordination supervision model and provide training to Mental Health Supervisors (MHS-1s) on how to supervise MHCCs use of evidence-based decision-making and best practices for care coordination.
- Develop provider supervision model and provide training to agencies on how to supervise the use of evidence-based services.
- Develop a network of trainers in evidence-based services. Currently there are only a few individuals with the ability to train on EBS. Widespread dissemination and integration of EBS is not possible with only a few trainers.

3.1.2b Year 2 Internal Objectives:
- A care coordination supervision model built around the use of evidence-based decision-making is developed and 85% of MHS-1s are trained on the use of this supervision model.
- A provider supervision model also built around the use of evidence-based decision-making is developed and 75% of agencies are trained on the use of this supervision model.
- A network of individuals will be identified to become trainers with at least one trainer per evidence-based services track.

3.1.3a Years 3 and 4 Implementation Strategies:
The integration of evidence-based services into the system of care should begin to stabilize itself to the point where gains in knowledge can be sustained through

the work of the developed network of trainers who will continue to train as knowledge around evidence-based services continually expands and as providers change and FGC staff turnover occurs. The focus moves away from preparing FGC staff, to ensuring the highest stakeholder participation in stakeholder meetings, so that a larger audience is reached.

3.1.3b Years 3 and 4 Internal Objectives:

- 85% of CAMHD providers and FGC staff will be trained in relevant evidence-based services.
- 85% of MHCCs will be trained and prepared to lead stakeholder discussions regarding evidence-based decision-making.
- There will be at least one EBS trainer per track whose training services are available to providers.
- A representative of 75% of stakeholder agencies will participate in these stakeholder meetings to discuss evidence-based services and principles.

3.2 *Performance Target #2: Establish a mechanism for the ongoing evaluation of the use and effectiveness of evidence-based services.*

3.2.1a Year 1 Implementation Strategy:

Where the first performance target focused on implementation, this second performance target focuses on the evaluation piece of the system. Therefore, the primary focus of the first year for this performance target is the establishment of protocols and internal mechanisms that will allow CAMHD to measure these evidence-based practice elements. The CAMHD Clinical Director and Research and Evaluation Specialist will lead this effort.

3.2.1b Year 1 Internal Objective:

Evaluation tools and strategies for measuring the use of evidence-based approaches will be completed, including monitoring protocols

3.2.2a Year 2 Implementation Strategies:

After the evaluation tools and strategies are developed in Year 1, the following represent the next steps in the implementation of this performance target:

- Assess the impact of current practice on family and provider satisfaction through the Provider Survey of Family Satisfaction and HFAA Survey of Family Satisfaction.
- Assess the impact of current practice on child/youth outcomes, and utilization patterns.

3.2.2b Year 2 Internal Objectives:

- For each of the surveys, data from 20% of the registered CAMHD population will be gathered.
- Data regarding the impact of current practice on child/youth outcomes, and utilization patterns, is gathered for review from 65% of the CAMHD registered population.

3.2.3a Year 3 Implementation Strategies:
As outcome data become available for review through CAMHMIS, CAMHD will evaluate these data to examine the impact of evidence based services on outcomes.

3.2.3b Year 3 Internal Objectives:

- For each of the surveys, data from 30% of the CAMHD registered population will be gathered.
- Data regarding the impact of current practice on child/youth outcomes, and utilization patterns, is gathered for review from 75% of the CAMHD registered population.
- A data report summarizing the local impact of evidence-based approaches is completed and distributed.

3.2.4a Year 4 Implementation Strategies:

- As outcome data become available for review through CAMHMIS, CAMHD will evaluate these data to examine the impact of evidence-based services on outcomes. Additionally in Year 4, CAMHD and the EBS Committee will work together to train CAMHD staff and provider agencies, on how to utilize these local evidence reports to guide practice/case management decisions.

3.2.4b Year 4 Internal Objectives:

- The objective in assessing impact through the provider and family satisfaction surveys, is to have data gathered from 40% of the CAMHD registered population.
- Data regarding the impact of current practice on child/youth outcomes, and utilization patterns, is gathered for review from 85% of the CAMHD registered population.
- An updated report summarizing the local impact of evidence-based approaches is completed and distributed.55% of CAMHD staff and Provider Agency staff are trained on how to interpret and use the CAMHD evidence reports to guide practice/case management decisions.

3.3 *Performance Target #3: Promote the sustained and appropriate application of evidence-based services and principles: Facilitation*

3.3.1a Year 1 Implementation Strategies:
The third piece of integrating evidence-based services into system design and implementation is the facilitation of discussion around issues and concerns with implementation, and the dissemination of user-friendly information on specific targeted populations to those interacting with those populations.

- Develop fact sheets for relevant parties to make relevant knowledge available to address the needs of specific targeted populations.

- Conduct stakeholder meetings to promote understanding and appropriate use of evidence-based decision making. At these meetings, gather feedback from stakeholders about where evidence is absent or inaccessible for key decisions.

3.3.1b Year 1 Internal Objectives:

- Fact sheets for all target populations developed.
- A representative from 55% of stakeholder agencies provides guidance about key areas that are lacking evidence to inform key decisions.

3.3.2a Year 2 Implementation Strategies:

- Conduct stakeholder meetings to promote understanding and appropriate use of evidence-based decision making. At these meetings, gather feedback from stakeholders about where evidence is absent or inaccessible for key decisions.
- The CAMHD Executive Management Team will begin to convene meetings to coordinate, as a part of the system design, incentives for the use of and commitment to evidence-based services. CAMHD providers need to be shown that CAMHD is committed to this effort, and that there is some tangible benefit for providers in implementing an evidence-based service system.

3.3.2b Year 2 Internal Objectives:

- Representatives from 65% of stakeholder agencies will participate in the meetings and 65% of them will provide feedback. This will illustrate a desire on the part of providers, to participate in this integration effort.
- The CAMHD Executive Management Team will have completed meetings to coordinate incentives for evidence-based services as part of system design

3.3.3a Year 3 Implementation Strategies:

- Continue to conduct stakeholder meetings to promote understanding and appropriate use of evidence-based decision making. At these meetings, gather feedback from stakeholders about where evidence is absent or inaccessible for key decisions.
- The first reviews of the efforts in Years 1 and 2 will be disseminated locally and nationally. Promotion of the efforts in Hawaii around this area are key to gaining local and national support, which will in turn, provide sustainability and long term success.

3.3.3b Year 3 Internal Objectives:

- Representatives from 75% of stakeholder agencies will participate in the meetings and 75% of them will provide feedback. This will illustrate a desire on the part of providers, to participate in this integration effort.

- Publications and presentations regarding our information on the effectiveness of evidence-based services in Hawaii are submitted/conducted.

3.3.4a Year 4 Implementation Strategies:

- Continue to conduct stakeholder meetings to promote understanding and appropriate use of evidence-based decision making. At these meetings, gather feedback from stakeholders about where evidence is absent or inaccessible for key decisions.
- The second reviews of the efforts in Years 1-3 will be disseminated locally and nationally. Promotion of the efforts in Hawaii around this area are key to gaining local and national support, which will in turn, provide sustainability and long term success.

3.3.4b Year 4 Internal Objectives:

- Representatives from 75% of stakeholder agencies will participate in the meetings and 75% of them will provide feedback. This will illustrate a desire on the part of providers, to participate in this integration effort.
- Publications and presentations regarding our information on the effectiveness of evidence-based services in Hawaii are submitted/conducted.

Goal 4: CAMHD and its provider agencies will routinely evaluate performance data and apply the findings to guide management decisions and practice development.

4.1 *Performance Target #1: Expand and improve the existing operational evaluation and supervision system based on routine practice measures and timely information that is increasingly clinically relevant and is readily exchanged in collaborative relationships with providers and partner agencies*

4.1.1a Year 1 Implementation Strategies:

The goal is to impact overall accessibility and utility of evaluation information in order to support daily operations for impacting better practice and outcomes. The strategy is to review current processes, develop support tools and to implement these within the current supervision structure.

- Define a set of standard forms and reports that summarize relevant data in a clinically meaningful fashion and clarify relations between data gathering and decision-making.
- Develop CAMHMIS clinical/supervision module to implement data gathering and reporting.
- Sustain group and individual supervision, case presentations, monthly performance appraisals, individual supervision plans, and CSP audit tools as key supervision strategies.

- Maintain the care coordinators as the core mechanism for sharing information among child serving entities.
- Obtain external review of monitoring system.

4.1.1b Year 1 Internal Objectives:

- Forms and clinical report produced and approved; decision-making guidelines developed.
- Clinical module completed and operational.
- 100% of staff with current ISPs; 100% of children and youth with current CSPs; and 85% compliance with CSP quality indicators.
- 90% completed CAFAS, CALOCUS, and Achenbach CBCL parent data quarterly.
- Decrease in missing data for multi-agency involvement fields in CAMHMIS.
- Execute contract for annual review of system.

4.1.2a Year 2 Implementation Strategies:

- Sustain group and monthly individual supervision, case presentations, performance appraisals, individual supervision plans, and CSP audit tools as key supervision strategies.
- Provide training and technical assistance on clinical processes and clinical/supervision module.
- Maintain the care coordinators as the core mechanism for sharing information among child serving agencies.
- Establish or maintain a mechanism for local level interagency management discussion in each district.

4.1.2b Year 2 Internal Objectives:

- 100% of staff with current ISPs; 100% of children and youth with current CSPs; and 85% compliance with CSP quality indicators.
- 90% completed CAFAS, CALOCUS, and Achenbach CBCL parent data quarterly; improved outcomes on these measures.
- Improve training evaluation ratings; increase in # of clinical module reports accessed.
- Decrease in missing data for multi-agency involvement fields in CAMHMIS.
- Increase in # of child-serving entities participating in local level inter-system management discussions.

4.1.3a Year 3 Implementation Strategies:

- Sustain group and monthly individual supervision, case presentations, performance appraisals, individual supervision plans, and CSP audit tools as key supervision strategies.
- Establish a mechanism for local level interagency management discussion in each district.

- Provide ongoing support and technical assistance on clinical processes and clinical/supervision module.
- Conduct monitoring and assessment of clinical processes and clinical/supervision module adherence.
- Support electronic sharing including DOE's data system, descriptions of joint data sets, and system requirements.

4.1.3b Year 3 Internal Objectives:

- 100% of staff with current ISPs; 100% of children and youth with current CSPs; and 85% compliance with CSP quality indicators.
- 90% completed CAFAS, CALOCUS, and Achenbach CBCL parent data quarterly and improved outcomes on these measures.
- Increase in # of child-serving entities participating in local level inter-system management discussions.
- Increase in # of clinical reports accessed; and an increasing trend in user satisfaction.
- Multi-agency reports developed.

4.1.4a Year 4 Implementation Strategies:

The sufficiency and quality of CSPs have improved to a level that can be sustained through broad-level monitoring. Participation in local level inter-system management discussions should be at a high and consistent level.

- Conduct monitoring and assessment of clinical processes and clinical/supervision module adherence.
- Support electronic sharing including ISPED, descriptions of joint data sets, and system requirements.

4.1.4b Year 4 Internal Objectives:

- Increase in # of clinical reports accessed and an increasing trend in user satisfaction.
- Multi-agency reports will have been developed.

4.2 *Performance Target #2: A clearly defined, decentralized, streamlined quality monitoring and improvement system that involves families, multiple agencies, and internal quality assurance personnel with clear direction for practice and policy decisions in the context of a knowledge-based learning organization.*

4.2.1a Year 1 Implementation Strategies:

- Clear specifications of CAMHD monitoring procedures and accountability systems with the goal of moving from state-level to local monitoring based on the results of state reviews. The first year focuses on conducting state level review and the scoring system to guide decentralization. The decentralization process will begin with FGCs and move to provider agencies. Through operationalizing and specifying the desired quality of monitoring, local-level accountability systems will be built by meeting

monitoring standards. Operational definitions and procedures for monitoring FGCs, providers, and Central Office as well as case-based reviews will be developed with input from key stakeholders

- Central Office will conduct in-depth reviews of FGC performance, provider performance and overall CAMHD performance measures.
- Also in this first year, recognizing the importance of having family participation in these evaluations and performance management reviews, a plan will be developed to involve families in this area.

4.2.1b Year 1 Internal Objectives:

- Review protocols for each monitoring component will be developed.
- Annual reports on the Central Office reviews of the FGCs, will be completed in a timely fashion.
- Family participation procedures will be specified in the monitoring protocols.
- Provider and Central Office review are consistently conducted within established protocol.

4.2.2a Year 2 Implementation Strategies:

- Implement a plan to involve families in evaluation and performance management reviews.
- Provider and Central Office reviews will be sustained at the state level.
- Central Office will conduct in-depth reviews of FGC performance.
- Monitoring protocols will be refined as necessary to meet changing environments and needs.
- The CAMHD Chief and the CAMHD Performance Manager will begin to explore agreements for interagency monitoring. Interagency monitoring has informed and guided systems development toward better integration and coordination around youth with multi-agency involvement.
- The CAMHD Performance Manager will facilitate the move towards a system of internal case-based reviews for provider agencies with less external monitoring based on sustained quality performance on these reviews, and an eventual move towards self-monitoring capacities.
- The Leadership Framework developed in Year 1, along with community representatives, research professionals, and the CAMHD Research and Evaluation Specialist, will work to develop the capacity to perform and support special, controlled studies in local areas, including the evaluation of prevention, specific populations, and longer-term follow-up.

4.2.2b Year 2 Internal Objectives:

- Increased # of family members involved in the review and evaluation process.
- Annual reports will be completed that describe level of performance so as to guide decentralization.
- Monitoring protocols are revised as needed.

- A completed work plan for interagency discussion regarding integrated monitoring.
- Increase in the # of provider agencies conducting internal monitoring using case-based reviews.
- Special study and evaluation reports will be completed and appropriately distributed.

4.2.3a Years 3 and 4 Implementation Strategies:

- Sustain family involvement in evaluation and performance management reviews.
- Sustain Central Office reviews at the State level.
- Monitoring protocols will be refined as necessary to meet changing environments and needs.
- The Leadership Framework developed in Year 1, along with community representatives, research professionals, and the CAMHD Research and Evaluation Specialist, will work to develop the capacity to perform and support special, controlled studies in local areas, including the evaluation of prevention, specific populations, and longer-term follow-up.
- FGC reviews accomplished through internal reviews and internal monitoring.
- Central Office will provide validation of internal reviews/FGC reviews and technical assistance/feedback based on a leveling system to determine the extent of external monitoring needed.
- CAMHD will continue to move towards a system of internal case-based reviews for provider agencies with less external monitoring based on sustained quality performance on these reviews, and an eventual move towards self-monitoring capacities.

4.2.3b Years 3 and 4 Internal Objectives:

- Increase in the # of family members involved in the review and evaluation process.
- Annual reports for reviews are completed in a timely fashion.
- Protocols are revised as needed.
- Special study and evaluation reports are completed.
- Quarterly reports on the internal FGC reviews will be provided to Central Office.
- FGC feedback reports and statewide aggregate reports will be produced.
- Increase in the # of provider agencies conducting internal monitoring using case-based reviews.

4.3 *Performance Target #3: Stakeholder communications that tell our story of success in a user-friendly, digestible and inspirational fashion to professional, legislative, community, and family groups and incorporates their feedback in measure selection, data interpretation and system design.*

4.3.1a Year 1 Implementation Strategies:

- To strengthen our communication with stakeholders and the public, CAMHMIS will produce daily reports for frontline use and more user-friendly summary reports and newsletters. Professional support will be added to make communication and information more available to the general public. Local and national dissemination will be achieved through encouraging staff to publish their work with CAMHD. CAMHD's Research and Evaluation Specialist, MIS, and Clinical Director, will facilitate the development of comprehensive clinical summary reports with clinical outcomes, diagnosis, service history, and fiscal information.
- Within the first year, CAMHD's Assistant Chief, the FGC Branch Chiefs, and HFAA will develop a media plan to include a POS contract with a PR agency to provide technical assistance to CAMHD for marketing, including district newsletters and other such marketing tools.
- The annual summary report will be revised and included in that process will be the solicitation of feedback about desired content from key stakeholders.
- Beginning in the first year for this performance target, CAMHD, HFAA, and University/Community College faculty and students will work to build the internal capacity to present and publish on a national level through training, increased data availability, and partnerships with external researchers.

4.3.1b Year 1 Internal Objectives:

- An array of clinical summary reports will be available for retrieval on a daily basis
- Newsletters, press releases, and media coverage will be developed.
- The annual summary report is revised.
- There will be an increase in the # of published articles and national presentations.

4.3.2a Year 2 Implementation Strategy:

CAMHD's focus will be on working to build the internal capacity to present and publish on a local and national level through training, increased data availability, and partnerships with external researchers.

- Newsletters, press releases, and media coverage will be continued and expanded.

4.3.3b Year 2 Internal Objectives:

There will be an increase in the # of published articles and presentations.

4.3.4a Years 3 and 4 Implementation Strategies:

The primary focus will be on working to build the internal capacity to present and publish on a national level through training, increased data availability, and partnerships with external researchers. Building the capacity internally will create a more sustainable set of achievements in this area and will allow for consistent

communications to stakeholders telling the success stories of our children and youth and their families. Newsletters, press releases, and media coverage will be continued and expanded.

4.3.4b Years 3 and 4 Internal Objectives:

- Increase in the # of published articles and national presentations.

Goal 5: The business practices implemented throughout CAMHD and its provider agencies will ensure high quality and accountable operations.

5.1 *Performance Target #1: All CAMHD staff need to understand their roles and responsibilities, scope of authority, and be held accountable for their performance.*

5.1.1a Year 1 Implementation Strategies:

CAMHD strives to ensure that its internal operations reflect good business practice. CAMHD interprets "business practice" to be about how an entity functions in all areas and at all levels. "Good" business practice means a work environment and infrastructure that is fiscally efficient and appropriate, maximizes and appropriately uses available resources, is able to internally monitor itself to assure that problems are addressed in an efficient and effective manner, has a well established and consistent supervisory structure, can track its performance through established performance measures, and is compliant with all federal, state, and local laws, rules and regulations.

- In the first part of the year, CAMHD managers, Branch Chiefs, and Personnel staff will conduct a detailed workflow analysis. In order to assess what changes may need to occur to ensure the quality and accountability of CAMHD operations; CAMHD needs to know what work is coming in, how often, from whom, to whom, and how and when it leaves CAMHD.
- In the second half of the year, a Staffing/Business Plan will be developed to address the results of the workflow analysis, including a discussion of relevant positions and position descriptions and any necessary supporting training requirements. In developing the Staffing/Business Plan, CAMHD will also update all relevant position descriptions, identify all training needs tied to specific positions/functions, and then incorporate these into the CAMHD Training Plan. A well- constructed Staffing/Business Plan will provide CAMHD with a basis to review the efficiency and accountability of its operations.
- CAMHD will facilitate the integration of the confidentiality and privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) into the daily practice of CAMHD and its provider agencies. Policies & Procedures will be revised and/or developed as needed, all CAMHD staff will be trained on these revised/developed P&Ps, and provider agencies will be provided consultative assistance as they work to

become HIPAA compliant. HIPAA is a Federal law that mandates all covered entities to meet a number of specific requirements around the protection of a client's privacy and protected health information. CAMHD is working within the Department of Health's department-level HIPAA effort and throughout the first year of this plan, will continue to work towards meeting the identified deadlines for compliance.

5.1.1b Year 1 Internal Objectives:

- The workflow analysis will be completed within the first nine months.
- The development of the Staffing/Business Plan and revision of the Training Plan will be initiated.
- 100% of position descriptions will be updated where necessary. Updated position descriptions allow CAMHD employees to have a clearer understanding of their roles and responsibilities.
- CAMHD will be in compliance with HIPAA Privacy requirements, whereby all P&Ps will have been developed and/or revised as needed, all CAMHD staff will be trained on these new processes, and provider agencies will have received adequate consultative assistance.

5.1.2a Year 2 Implementation Strategies:

- The first year for this performance target focused on laying the foundation for CAMHD employment practices. Update and revise the CAMHD employee handbook.
- Develop an orientation and expanded new-employee mentoring program.
- Develop and implement in-service training courses targeted towards a major portion of CAMHD staff.
- Continue to facilitate the integration of HIPAA requirements into the daily practice of CAMHD and begin to monitor compliance efforts.

5.1.2b Year 2 Internal Objectives:

- The CAMHD employee handbook is revised.
- An orientation and mentoring program for new staff is developed and implemented.
- In-service training course curricula are developed and initial trainings have begun.
- Continued compliance with HIPAA privacy requirements, and achieving compliance with HIPAA transactions/code sets requirements.

5.1.3a Years 3 and 4 Implementation Strategies:

Focus is on continued HIPAA compliance and the continuation of in-service training courses for CAMHD staff. If CAMHD staff are to be held individually accountable for their performance, part of CAMHD's responsibility is to ensure that they are properly oriented, mentored, and trained.

5.1.3b Years 3 and 4 Internal Objectives:

- Continued compliance with HIPAA privacy requirements, and obtaining compliance with HIPAA transactions/code sets requirements.
- 100% of CAMHD staff have received appropriate trainings.

5.2 *Performance Target #2: Consistent enforcement of fiscal management processes to ensure good business practice, fiscal responsibility, and system accountability.*

5.2.1a Year 1 Implementation Strategies:

Part of good business practice is CAMHD's obligation to ensure that funds are spent in a fiscally responsible manner. This includes a detailed and consistently enforced fiscal management process that requires implementation of the following strategies:

- Appropriate facilitation and application of the competitive bid process. The majority of CAMHD providers are contracted through the competitive bid/Request For Proposal (RFP) process. CAMHD adheres to strict policies and procedures regarding the RFP process and must continue to do so in order to gain the trust of stakeholders about the integrity of the process.
- The Utilization Management (UM) Plan is to ensure that CAMHD is utilizing services efficiently, in the most appropriate manner, and providing for the highest quality of care for CAMHD's children and youth. CAMHD will implement the UM Plan to conduct targeted utilization review of CAMHD's most costly services. This review will help CAMHD determine if there is any need for the expansion of resources and service capacity. Additional strategies in the UM Plan include interaction and collaboration with the Juvenile Justice system, consistent oversight of provider agencies, FGC Psychiatrists/Clinical Directors co-managing cases at the higher hospital-based residential level of care, and regular review of established service thresholds.
- Assure that utilization and flow of youth moving to and from more intensive services are examined and monitored on an ongoing basis.
- A clear protocol will be developed around the routing and review of the CAMHD monthly *Summary of Services*.
- Define the requirements necessary to automate CAMHD's accounting function to allow CAMHMIS to properly interface with DAGS accounting system.
- CAMHD will continue to perform semi-annual MHCC caseload analysis, so that staffing patterns at the FGCs can be consistently monitored.
- Fully implement PAS requirements for all CAMHD staff. CAMHD managers need to ensure that all PAS requirements are current for each of the employees they supervise. Current and consistent PAS indicate regular and appropriate supervision of employees, so that any performance challenges are being addressed in a timely manner.

- Consistent monitoring of compliance with each sectional budget. CAMHD sections and Branches are moving towards a system where they will be responsible for remaining within their own budgets, not only on the personnel/administrative side, but also on the service side.

5.2.1b Year 1 Internal Objectives:

- In relation to the competitive bid process, little to no appeals of RFP awards or resolution of RFP appeals in CAMHD's favor by the State Procurement Office (SPO).
- Implementation of the UM Plan and all the included strategies, should result in a consistent decrease in placements and length of stay in mainland placements, hospital-based residential placements, and out-of-home placements.
- Protocol for the routing and review of the monthly *Summary of Services* are completed and implemented.
- Requirements to automate CAMHD's accounting function are defined.
- MHCC caseloads are analyzed two times in the year.
- 100% of staff have updated/current PAS.
- All sections within CAMHD are operating within their budgets.

5.2.2a Year 2 Implementation Strategies:

- CAMHD's compliance program with comprehensive claims review and post-review analysis to be completed.
- Appropriate facilitation and application of the competitive bid process whenever possible.
- Implement the UM Plan to conduct targeted utilization review of most costly services. Additional strategies in the UM Plan include interaction and collaboration with the Juvenile Justice system, consistent oversight of provider agencies, FGC Psychiatrists/Clinical Directors co-managing cases at the higher hospital-based residential level of care, and regular review of established service thresholds.
- Timely completion of monthly *Summary of Services*.
- Completion and implementation of CAMHD automated accounting function to allow CAMHMIS to properly interface with DAGS accounting system.
- Continue to perform semi-annual MHCC caseload analysis.
- Continue to fully implement PAS requirements for all CAMHD staff.
- Strict internal adherence to 30-day reimbursement goal from the time the provider submits the claim.
- Consistent monitoring of compliance with each sectional budget.
- Claim audits will be performed based on a random sample of all claims submitted during the fiscal year, and results will be extrapolated to the full set of claims.

5.2.2b Year 2 Internal Objectives:

- Comprehensive claims review and post-review analysis is completed.
- In relation to the competitive bid process, little to no appeals of RFP awards or resolution of RFP appeals in CAMHD's favor by the State Procurement Office (SPO).
- Implementation of the UM Plan and all the included strategies, should result in a consistent decrease in placements and length of stay in mainland placements, hospital-based residential placements, and out-of-home placements.
- *Summary of Services* reports are distributed monthly.
- CAMHD's automated accounting function is completed and implemented.
- MHCC caseloads are analyzed two times in the year.
- 100% of staff have updated/current PAS.
- Decrease in amount of 30-day reimbursement goals missed.
- All sections within CAMHD are operating within their budgets.
- Reduction in CAMHD over-payments to provider agencies; No successful challenges to the CAMHD random sampling methodology through the CAMHD appeals process or through other formal processes.

5.2.3a Years 3 and 4 Implementation Strategies:

By this time, the processes, protocol, and tools will have been developed. These years are for implementing those strategies in a consistent and accountable manner.

- Appropriate facilitation and application of the competitive bid process whenever possible.
- Implement the UM Plan to conduct targeted utilization review of most costly services. Additional strategies in the UM Plan include interaction and collaboration with the Juvenile Justice system, consistent oversight of provider agencies, FGC Psychiatrists/Clinical Directors co-managing cases at the higher hospital-based residential level of care, and regular review of established service thresholds.
- Timely completion of monthly *Summary of Services*.
- Continue to perform semi-annual MHCC caseload analysis.
- Continue to fully implement PAS requirements for all CAMHD staff.
- Strict internal adherence to 30-day reimbursement goal from the time the provider submits the claim.
- Consistent monitoring of compliance with each sectional budget.
- Claim audits will be performed based on a random sample of all claims submitted during the fiscal year, and results will be extrapolated to the full set of claims.

5.2.3b Years 3 and 4 Internal Objectives:

- In relation to the competitive bid process, little to no appeals of RFP awards or resolution of RFP appeals in CAMHD's favor by the State Procurement Office (SPO).

- Implementation of the UM Plan and all the included strategies, should result in a consistent decrease in placements and length of stay in mainland placements, hospital-based residential placements, and out-of-home placements.
- *Summary of Services* reports are distributed monthly.
- MHCC caseloads are analyzed two times in the year.
- 100% of staff have updated/current PAS.
- Decrease in amount of 30-day reimbursement goals missed.
- All sections within CAMHD are operating within their budgets.
- Continued reduction in CAMHD over-payments to provider agencies; No successful challenges to the CAMHD random sampling methodology through the CAMHD appeals process or through other formal processes.

5.3 *Performance Target #3: Implementation of a Strategic Management Information Systems Plan that will allow for identification of the appropriate systems direction for the CAMHD and how it can further utilize technologies to facilitate meeting its mission, goals, and objectives.*

5.3.1a Year 1 Implementation Strategies:
Strategies within this performance target will focus on a target environment consisting of updating technology infrastructure and organization, enhancing computer applications in support of the CAMHD's business processes, and creating additional administrative applications.

- Implementation of QUEST-required HIPAA modifications. CAMHMIS managers were generally briefed by QUEST on what submission format modifications would be required this year due to HIPAA requirements. More details will be forthcoming, however QUEST has mandated some changes that must be made before the end of this first year.
- Implementation of HIPAA requirements that affect Provider reporting and billing system. The current CAMHD provider reporting system is not HIPAA compliant and requires significant work in order to meet federal guidelines. Data transmission formats as well as system infrastructure will need to be replaced. Current plans are to seek bids using contractor to build application portion and use MIS staff for database, infrastructure, and replication work. All programming and forms will also then become the property of CAMHD.
- In the first year, CAMHD will work to secure funding for workstation upgrades for FGCs and Central Office (hardware and software operating systems) and for installation of a Secure Broadband network that supports necessary communications. The majority of current CAMHD machines are inadequate for the latest supported versions of Microsoft Office or any other mainstream application software, causing great difficulty for users in running basic word-processing functions as well as operationally critical MIS systems. Speed and the inability to view mainstream documents are of major concern. The ability to become HIPAA compliant is also of concern with these older machines and systems.

- Consistent fiscal year systems maintenance and modifications on an annual basis. This is a re-occurring yearly process that is needed to perform minor updates and modifications from one fiscal year to the next. It covers the entire system but focuses heavily on Service Authorization and Billing.
- Development of a Clinical Supervision module to promote greater capacity and enhance performance of the CAMHD provider network. This module will utilize data from multiple system resources to profile and monitor various objects within the service delivery system. The Module will also help to standardize and centralize supervision processes across the state. Improved supervision will promote greater capacity and enhance performance of the CAMHD provider network and will also help to promote greater levels of integrity and the use of evidence-based interventions.

5.3.1b Year 1 Internal Objectives:

- Full implementation of QUEST-required HIPAA modifications.
- CAMHMIS is HIPAA compliant.
- Required funding for workstation upgrades and Secure Broadband network installation secured. The network is installed and all FGC and Central Office workstations are upgraded.
- CAMHMIS is current and updated to match the existing needs prior to the beginning of the new fiscal year.
- Completion and implementation of the Clinical Supervision module.

5.3.2a Years 2-4 Implementation Strategies:

CAMHMIS should be ready to move into a sustainability phase as it is now HIPAA compliant and the Clinical Supervision module is complete. Building off of the accomplishments in Year 1, the following strategies will help support good business practices throughout the system.

- Website is regularly updated with updated information, news, documents for publishing, and other information for public access.
- MIS will conduct comprehensive computer training for all CAMHD staff in the following areas: Orientation to CAMHMIS and email for new users; Oracle Discoverer Training for all users; Microsoft Word training for new users; Microsoft Excel training for specialty users; Microsoft Access training for interested specialty users; Clinical Module training; and further training on new modules as developed.

5.3.2b Years 2-4 Internal Objectives:

- Website is current, user-friendly, and accessible.
- Improvement of CAMHD staff competency in all defined areas; Decrease in requests for MIS assistance in the areas trained on.

SECTION III

EXTERNAL FACTORS

Introduction

When completing a strategic plan, it is important that consideration be given to those factors external to the agency that may affect, either positively or negatively, the successful implementation of the plan. When CAMHD gave consideration to those external factors, the following areas emerged.

Budget

CAMHD will need to successfully advocate, with the department, budget and finance and the members of the legislature, to maintain the current budget allocation. The activities identified in this strategic plan are based upon CAMHD fiscal year '03 funding appropriation.

Given the tight economic situation of the state and the uncertain priorities of upcoming leadership changes, there must be targeted efforts to educate leadership to sustain the current budget allocation. If CAMHD is required to absorb any unexpected significant budget reductions during the FY'03-FY'06 time period, this plan will not be able to be implemented as developed.

In order to successfully maintain the current budget, CAMHD will provide annual justification to department, budget & finance, and the legislature.

Legislative Factors

Given that FY '03 is an election year, the outcome of the election has just been determined. Hence, the Chair of Health and Finance/Ways and Means Committees are not known at this time. CAMHD will need to work closely with the legislative leadership to support the efforts outlined in this plan. The Felix Investigative Committee is expected to continue their efforts to ensure accountability of the Felix Compliance efforts. CAMHD will support this committee in their efforts while also looking to engage committee leadership in supporting children's mental health initiatives.

Federal Court Involvement

CAMHD will need to successfully demonstrate sustainability of efforts to monitor and evaluate system compliance with the Felix Consent Decree. There is a specific *Sustainability Plan* that needs to be successfully implemented. This plan provides specific commitments made to federal court detailing CAMHD activities and resources.

CAMHD also needs to continue efforts to show compliance with DOJ Settlement Agreement. Should CAMHD be found in compliance with DOJ Settlement Agreement, a similar sustainability plan would have to be submitted and implemented.

Medicaid Requirements

In order for CAMHD to maintain the ability to maximize federal revenue, the Division must maintain a Medicaid Health Plan status. This requires that CAMHD continue to meet all requirements of the MQD quality assurance audit.

At the present time, the Division continues to strive to renegotiate a more competitive capitation rate that is more reflective of the costs of services to seriously emotionally disturbed youth. Discussions are underway with MQD to finalize the MOA between MQD and CAMHD.

A competitive capitation rate will allow CAMHD to offset state expenditures of services with federal funds. Any capitation rate that is not sufficiently representative of costs will result in more drain on the state's general funds. Therefore, CAMHD will continue working with MQD to ensure completion of this MOA.

HIPAA Requirements

CAMHD and its provider agencies, business associates (as defined by HIPAA), and trading partners (as defined by HIPAA) must be prepared to meet the Health Insurance Portability & Accountability Act (HIPAA) requirements by April 16, 2003 for the Privacy Rule and by October 16, 2003 for the Transactions/Code Sets Rule.

Supports must be in place to ensure that provider agencies are able to properly interface with CAMHD prior to that time. Any provider agency that is not able to meet HIPAA requirements will require close review.

In order to ensure that there is not an interruption in services to children and youth, CAMHD will be working to ensure Division compliance and will also provide consultation and technical assistance to providers as requested/needed.

Departmental Requirements

Given the potential changes in departmental administration, there is a strong need for CAMHD to brief any new departmental leadership about this plan. Any change in departmental support for children's mental health will significantly impact the implementation of this plan.

FERPA Requirements

There are significant protections regarding confidentiality that are offered to children and families in accordance with the Family Education Rights & Privacy Act (FERPA). Since many of CAMHD services emanate from a student's educational plan, this requires that CAMHD records be protected in accordance with FERPA.

Yet, this need to protect confidentiality often places CAMHD personnel in a bind of not sharing information with the Medicaid agency. We are presently working with the Attorney General's office to resolve the challenges that cause these problems.

SECTION IV:

Program Evaluation

Previous Evaluations

In the past several years, CAMHD has had many audits by the Legislative Auditor's office. These audits provided some guidance about specific areas that may have needed attention. However, these reports more often summarized findings that the Department was already aware of and in the process of addressing. Unfortunately, these audits also often contained misinformation or unsupported conclusions about CAMHD. As these audit reports have been published, CAMHD has openly reviewed these documents and worked to address any issues identified by the Auditor.

In the recent years, there have also been numerous reports from the Felix Monitor regarding his assessment of CAMHD efforts to comply with the requirements of the Consent Decree. The CAMHD Management Team reviewed these reports as they were released, and efforts were made to address any areas of concern raised by the Felix Monitor.

There have also been several reports issued by the Department of Justice regarding the performance of CAMHD as it relates to the monitoring of the Child and Adolescent Residential Services (CARS). These reports have been primarily complimentary in the most recent years; however, any issue of concern that was raised by the DOJ was addressed as quickly as possible.

Last year, CAMHD contracted for an external independent monitoring of the CAMHD Implementation of MST. This was independent review conducted by University of California San Francisco (UCSF). This report was submitted to the Legislature as requested. This report identified the performance of the MST teams in Hawaii, and evaluated CAMHD's implementation of MST in the state.

Future Program Evaluation

In effort to assure periodic external objective evaluation of outcomes, CAMHD is committed to contracting for external review of system. On an annual basis, CAMHD will release a request for proposal for an independent review of CAMHD monitoring system and results.

This is fairly atypical of a public mental health system, and demonstrates CAMHD's true commitment to objective evaluation and accountability.

Information System Capacity

In order to continue ongoing monitoring and evaluation the information system must be kept current with emerging technology. Throughout this strategic plan, there is the identification of the necessary strategies for ongoing development of the Child & Adolescent Mental Health Management Information System (CAMHMIS).

SECTION V:

MANAGEMENT OF HIGH RISK ISSUES

Accountability for Compliance Program

CAMHD maintains a Compliance Program that promotes prevention, detection, and resolution of instances of conduct that do not conform to Federal and State law and Federal health care program requirements, as well as state ethics commission and business policies.

CAMHD's Compliance Program formally documents the Division's commitment to the elements of compliance and addresses specific areas of potential fraud. The Compliance Program is demonstrated through the distribution, to all employees, of a Standards of Conduct document as well as written policies and procedures that establish standard business practices to foster a high level of ethical and lawful conduct throughout the full scope of the Division's activities.

The CAMHD Compliance Officer maintains records of all Compliance Program activities. Appropriate notification of involved authorities occurs as indicated based upon the results of monitoring efforts.

Accountability for Results

CAMHD has integrated performance evaluation throughout the children's mental health system. This monitoring system evaluates both process and outcome indicators.

CAMHD evaluates child status by conducting a case based review of functioning, as well as evaluating results of functional status per standardized assessment tools, such as the CAFAS and Achenbach CBCL. CAMHD also reviews pro-social involvement, school attendance, law violations, days served in home.

CAMHD evaluates system performance through case based review methods, child and family satisfaction surveys, and traditional quality assurance measures. CAMHD evaluates complaints, sentinel events, outlier claims, and personnel turnovers.

CAMHD evaluates provider performance through intensive contract monitoring. The monitoring involves a combination of record review for process indicators, case based review, and child status outcomes.

The results of CAMHD performance monitoring are reported quarterly to CAMHD Management Team and at least annually to stakeholders.

Oversight of Sentinel Event/High Risk Programs

CAMHD requires all contract provider agencies and FGCs to report significant events in a timely manner. CAMHD maintains a Safety and Risk Management Committee (SARM) that reviews all sentinel events for patterns and trends that may emerge from incidents.

The SARM Committee refers all significant findings to the CAMHD Performance Improvement Steering Committee (PISC) for evaluation and recommended changes or actions with provider agencies.

The CAMHD Executive Management Team (EMT) also reviews high-risk sentinel events for immediate action on any given situation.

SECTION VI

STAKEHOLDER CONSULTATIONS

Introduction

CAMHD believes that in order to achieve positive outcomes for Hawaii's children and youth with mental health needs, the strategic planning must occur statewide and at the community levels. As such, many meetings and discussion groups were conducted to support this effort. The significant input is summarized below.

Members of the Legislature

Several meetings were conducted with members of the legislature to review issues of importance. Primary issues raised were: (1) The need for measurable outcomes to be a part of the plan; (2) Addressing the concerns around sharing of information between child-serving entities; (3) Early intervention services especially for the 3-5 at-risk population; (4) The need for after-school/after-hour programs; and (5) Addressing youth in the juvenile justice system with a focus on the treatment of juvenile sex offenders and the victims of sex abuse.

Department of Health

One meeting was held with representatives from the Department's Administrative Services Office, the Deputy Director, Personnel Services Offices, the Alcohol and Drug Abuse Division (ADAD), the Developmental Disabilities Division (DDD), and the Adult Mental Health Division (AMHD) to gather input and feedback into the draft Mission Statement, Populations, and Goals. The Department of Budget & Finance was also present at this meeting. The primary issues raised were: (1) Availability of resources to accomplish identified goals and objectives; (2) Practicality and feasibility of the plan; (3) The need to address youth with co-occurring substance abuse and mental health disorders; and (4) The need to improve and expand on transition services offered to youth transitioning from CAMHD to adulthood.

Department of Education

At the majority of the FGC-conducted community stakeholder meetings to discuss CAMHD's strategic planning effort, there was community/district level representation from the local schools. There was one meeting held with the Deputy Superintendent of Education and Director of Program Support and Development. The primary issues raised were: (1) How can DOE and CAMHD work together to address the need for prevention services/programs and early intervention (3-5) services and (2) The need to improve the communication and collaboration between the DOE and CAMHD.

Department of Human Services, Child Welfare Services

At the majority of the FGC-conducted community stakeholder meetings to discuss CAMHD's strategic planning effort, there was community/district level representation from local child welfare office. In addition, there was one meeting held with the Director of the Department of Human Services, as well as representatives from the Department's Child Welfare Services. In addition, at the majority of the FGC conducted community stakeholder meetings to discuss CAMHD's strategic planning effort, there was community/district level representation from DHS staff. The primary issues raised were: (1) The distinction between cultural competency and cultural awareness/respect; (2) Need to focus on what CAMHD has "control" over and what CAMHD can say it "will" do; (3) Need to make sure that "system of care" is used consistently throughout the document and also clearly defined; (4) Need to be clear about what Multi-Systemic Therapy (MST) is; and (5) Need to be sure to clearly address the MedQUEST-eligible population of children/youth.

Family Court/Juvenile Justice system

At the majority of the FGC-conducted community stakeholder meetings to discuss CAMHD's strategic planning effort, there was community/district level representation from Family Court staff (i.e. Probation Officers). The primary issues raised were: (1) Placement and treatment of the juvenile sex offender population; (2) Cross-agency/entity collaboration is sometimes difficult/acts as a barrier to getting needed services for a child/youth; (3) There needs to be clarity around the roles and responsibilities of the various child-serving agencies; and (4) It's hard for Family Court Probation Officers to have commitment to the system when they are often on-call when a youth is picked up at night/during "off hours", caseloads are often too high and many feel as though CAMHD has taken away resources.

CAMHD Provider Agencies

CAMHD providers/stakeholders attended the majority of the FGC-conducted community meetings to discuss CAMHD's strategic planning effort. The primary issues raised were: (1) Need to address whether or not focusing on evidence-based services limits the flexibility to use interventions that may work but that are not empirically supported; (2) CAMHD rates are too low for providers; (3) CAMHD reviews conducted of provider agencies are often approached from the wrong perspective/are adversarial in nature rather than collaborative around how to strengthen the system; and (4) Need to improve the communication/feedback mechanisms

Community Children's Councils

One meeting with the co-chairs of the state's Community Children's Councils (CCCs) was held. In addition, each Family Guidance Center Branch Chief invited their community's CCC representative to attend the community stakeholder meetings that each FGC conducted to engage the community in discussion around CAMHD's Mission Statement and identified goals. Out of those meetings, the primary issues raised were: (1) Collaboration among state child-serving entities needs to be improved so that movement through the process/system is as smooth as possible; (2) There is insufficient knowledge of the CASSP principles and there are a number of CASSP-related challenges that the rural areas of the state face, but may not be ready/open to accepting responsibility; (3) It is difficult to have equal ownership when many state entities and/or providers convey an attitude of believing that they know better than a parent/family, what's best for their child/youth; (4) Need to be sure to address target populations of victims of sexual abuse/molestation and prevention/early intervention for those children that are not special education students. The CCCs requested the opportunity to send representatives to the 2-day drafting meeting for this plan. One CCC Co-Chair accepted the invitation and has participated throughout the drafting of the management plan.

Families

A meeting was held with Hawaii Families As Allies (Hawaii's Statewide Family Organization) and included a majority of its Parent Partners (PPs) located in every FGC across the state. The HFAA Executive Directors also participated in the drafting of the management plan at the 2-day drafting meeting. The primary issues raised were: (1) The need to improve the interaction and relationship between the PPs and the FGC MHCCs, including working to increase family awareness of the availability of the PPs and the services/supports they can provide; (2) Cultural sensitivity is key to the system of care and must be focused on each child/youth's individual situation; and (3) Need to address the mental health needs of: victims of sexual abuse/molestation, youth with co-occurring substance abuse and mental health disorders, children/youth of incarcerated parents (i.e. stigma, separation, and trauma), and students at private and/or charter schools.

The Hawaii State Mental Health Council

CAMHD attended two meetings of the Council to discuss CAMHD's strategic planning efforts and a member of the Council attended the 2-day drafting meeting. The primary issues raised were: (1) Need to be sure to address populations of: children/youth who are non-educationally disabled but in need of mental health services and prevention population; (2) Should add one goal that is substantive and not process-oriented; (3) The use and application of evidence-based services within the system needs to be made clear to parents/families of

CAMHD children/youth and FGC staff, and needs to be more widely disseminated for public consumption; (4) There needs to be a focus on the clear definition/identification of barriers unique to specific communities (i.e. rural communities); and (5) De-stigmatization should be made a priority

Feedback from Public Hearing Process

Six public hearings were held regarding this plan. They were conducted in Hilo, Kauai, Central Maui, Honolulu, Windward Oahu and Leeward Oahu. There was limited input and participation in these meetings, even though formal notice was given regarding these meetings. Comments received included mainly questions regarding clarification of strategies and outcomes identified in the Plan.
In Section II, the question related to whether the data tracking, collection and analysis center on outcomes impacting individual children and youth? Response was given that yes, these outcomes were child outcomes.

In Section III, the question was how continued federal oversight might impact the success of implementing the strategic plan. Response was given that mores than federal oversight, changing legislative or departmental priorities could change the direction/impact the success of the plan.

In Section IV, the question was how CAMHD was going to obtain an external auditor to do the monitoring discussed. Response was given that CAMHD will follow all applicable state procurement guidelines, rules and regulations and that the results will be published. A primary overall concern was whether the plan addressed non-Felix children and youth who also do not have insurance. Response was given that yes, the plan does address this population. No other comments were received through the public hearing process.

SECTION VII

MANAGEMENT PLAN

Child and Adolescent Mental Health Division (CAMHD)
4-Year Strategic Plan
Management Plan for Year One
SECTION VII:

IMPLEMENTATION STRATEGY	TIMETABLE	RESPONSIBILITY	PERFORMANCE MEASURES
Goal 1: CAMHD has a responsibility to facilitate and support the shared ownership of the CAMHD vision mission, initiatives, and achieved outcomes. **1.1** *All child-serving entities have a clear understanding and appreciation of each other's roles and responsibilities in addition to their own:*			
• Development of a statewide leadership framework.	• Mos. 0-6	• CC	• Establishment of a statewide leadership framework.
• Implementation of the statewide leadership framework at the community and local level, through visits and discussions with community stakeholders throughout the state.	• Mos. 6-12	• CC, BCs	• Training and mentoring completed and interagency framework jointly presented to community stakeholders.

• Cultivation and improvement of the CAMHD internal management values and practices through:
  • Appropriate supervisory infrastructure.
  • Regular opportunities for feedback on work environment.
  • Integration of management values into everyday operations.
	• Mos. 0-12	• CC, CMs, BCs	• All CAMHD employees receiving consistent supervision and regular opportunity for feedback; All CAMHD employees embrace equal ownership for the system's accomplishments, challenges, and shortcomings.

1.2 *There will be adequate resources available for all child-serving entities in order to meet their statutory mandates and their obligation to Hawaii's children and youth.*			
• Implementation of a CAMHD State Plan	• Mos. 0-6	• CFRDS; CAC.	• Increase in amount of QUEST

Key to Abbreviations in "Responsibility" Column
CC=CAMHD Chief; BC=Branch Chief; CM=CAMHD Managers; CFRDS=CAMHD Financial Resources Development Staff; CAC=CAMHD Assistant Chief; CPS=CAMHD Personnel Staff; NTACs=National Technical Assistance Centers; EBS=Evidence based Services; HFAA=Hawaii Families As Allies; MHCCs=Mental Health Care Coordinators; CCD=CAMHD Clinical Director; CMD=CAMHD Medical Director; CPM= CAMHD Performance Manager; FMT=FGC Management Team; CPDS=CAMHD Practice Development Supervisor; CRES=CAMHD Research & Evaluation Specialist; CPISC=CAMHD Performance Improvement Steering Committee; FGC Quality Assurance Specialists; SMHC=State Mental Health Council; CP=CAMHD Planner; YC=Youth Council; DDBH=Deputy Director of Behavioral Health; CRMS=CAMHD Resource Management Supervisor; MACC=Multi-Agency Coordinating Committee; MIS=Management Information Systems; CCMS=CAMHD Contracts Management Supervisor; CCRU=CAMHD Claims Review Unit.

Amendment (QUEST funding) that includes a commitment to Evidence Based services.			reimbursements received.
• Begin to look at updating CAMHD statutes and also support the update of all child-serving entity statutes.	• Mos. 0-12	• CC; CAMHD Planner	• Statutory updates begun.

• Maximization of federal grant funding opportunities:
  • All agencies should have approved, and then hire, a full-time grant writer.
  • Overall training and education on researching grant opportunities and grant writing.
	• Mos. 0-12	• CC; CPS,; Hawaii's Universities and Colleges; NTACs.	• Increase in amount of federal funding opportunities received.
			• Full time grant writer hired for every child-serving entity.
			• Training and education completed.

• Integration of EB services into the system of care.	• Mos. 0-12	• EBS Task Force	• EBS are available statewide, can be evaluated, and implementation and evaluation is sustainable.
1.3 *Improvement in the active engagement of, and communication with, families and community organizations invested in the system of care:*			
• Provide each family entering into and already in the system, an informational packet and orientation on HFAA parent partners and services provided, to also include CCC flyer.	• Mos. 0-9 (initial effort)	• BCs; HFAA	• All new and current families are given this information; Increase in referrals to and utilization of Parent Partners.
• Encourage MHCCs to include informal contacts in their engagement with families.	• Mos. 0-6 (start-up) • Mos. 6-12 (implement ation)	• BCs	• MHCCs have begun to engage with families through informal contacts.

• Increase public awareness of the system's accomplishments.
  • Newsletter
  • Television Ads/Public Service Announcements
  • Public "Thank You's"
	• Mos. 0-12	• All of CAMHD staff; HFAA	• Increase in family satisfaction and true participation in the process, as measured by revised Family Satisfaction Surveys.

1.4 ***Increased*** *collaboration with Hawaii's university and community college institutions in training students in CASSP*			

Key to Abbreviations in "Responsibility" Column
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principles, EBS, and an evaluative manner of thinking. • Map out where the children's mental health labor force comes from/out of which disciplines. • Facilitate meetings/discussions with university and community college educators on how CAMHD can help them include these values/practices in their curricula. • Develop mini-modules that can be included in the curricula. • Offer to guest lecture in classrooms.	• Mos. 0-6 • Mos. 6-12 • Mos. 6-12 • Mos. 10-12	• CCD; CMD • CPDS • CPDS • CPDS	• Mapping completed. • At least 2 meetings have been held with identified CAMHD staff and university and community college educators. • Mini-modules covering different practice areas developed. • Offers to guest lecture are made.

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Child and Adolescent Mental Health Division (CAMHD)
4-Year Strategic Plan
Management Plan for Year One

Goal 2: The CAMHD and its providers will consistently adhere to the Hawaii CASSP principles. **2.1** ***Create*** *a community-based, accessible system of care through which families are guided by knowledgeable and experienced veteran staff.*			
• Educate, train and inform CAMHD stakeholders and families to understand populations served by CAMHD and the context of CASSP.	• Mos. 6-12	• All CAMHD staff w/contact with public; FGCs; HFAA	• Occurs at 100% of FGC community presentations.
• Research catalogues of formal and informal resources/supports currently available in the communities and through partner agencies/entities.	• Mos. 6-12	• BCs; CMs; HFAA	• Hard copies of catalogues made available in each FGC, for each PP, and for HFAA.
• Train all CAMHD staff to know and understand populations served and context of CASSP principles. • Provide teaching tools including examples of populations served and application of CASSP.	• Mos. 9-12	• CMs; CPDS; BCs; HFAA	• 85% of staff receive information; 85% trained; 100% of attendance documented.
• Collect information on consumer satisfaction with the system, inclusive of CAMHD, regarding implementation of CASSP principles.	• Mos. 6-12	• CRES; HFAA	• Data collected quarterly; annual report development begun.
• Continued integration of CASSP principles into supervision of care coordination.	• Mos. 0-12	• MHS-1s	• Integration is continued.
• Strategic Plan will be developed to address full continuum of mental health services for youth involved in the juvenile justice system, inclusive of expanding the leadership role of the Family Court Liaison Branch.	• Mos. 0-12	• CC; FCLB	• Strategic Plan to address youth involved with the juvenile justice system is developed.
• Coordinate the review and revision of the state's Juvenile Sex Offender (JSO) master plan. •	• Mos. 0-12	• CC; FCLB	• Review and revision completed.
2.2 *Ongoing education and public relations effort to broaden and improve attitudes, understanding and acceptance of families of children/youth with mental health needs.*			

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• Research existing CASSP related materials/literature that are family friendly.	• Mos. 0-9	• CMD; HFAA	• Comprehensive list of CASSP-related materials that are family-friendly is developed.
• Develop family/public friendly literature, which includes behavioral/functional examples for each CASSP principle, and insure focus group input.	• Mos. 0-9	• BCs; HFAA	• Brochures are developed w/minimum of one community group input per FGC.
• Integration of public stakeholders' logos on the Hawaii CASSP principle bookmarks.	• Mos. 0-12	• CMs	• Logos are integrated on brochure and there is a distribution plan.
• Develop newsletter highlighting family success stories as a method of positive public relations.	• Mos. 6-12	• CPM; HFAA	• Newsletter is published quarterly and there is a distribution plan.
• Co-training with FGC staff and HFAA on de-stigmatizing children's mental health, CASSP and related topics.	• Mos. 9-12	• CPDS; FGC Management Team; HFAA	• 1 co-training scheduled and conducted for each FGC; Flyers advertising training for each FGC; 100% development of training curriculum and agendas for each topic
• Distribution of family/public friendly literature which includes behavioral/functional examples for each CASSP principle.	• Mos. 9-12	• FGC Management Team; CPM; CPDS	• Brochure printed; 90% distribution to all individuals listed in distribution plan.
2.3 *Increase* *broader community involvement and development of resources to support children and youth and their families.*			
• Training and mentoring provided to all CAMHD staff to partner with HFAA to promote the CSP and strengths-based planning model.	• Mos. 0-12	• All CAMHD staff; HFAA	• 85% compliance with CSP quality indicators.
• Engagement of families will continue to be a priority, and targeted training will be ongoing.	• Mos. 0-12	• All CAMHD staff; HFAA	• Engagement of families and continued training occurs.
• Promote youth participation in planning.	• Mos. 0-12	• BCs	• 50% of youth participating in the CSP process statewide; 80% of youth participating satisfied with services (Youth Satisfaction Survey).
• Participate in community-based organizations (i.e.			

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Rotary, Chamber of Commerce, etc.). • Begin to develop peer education/mentoring/tutoring program. • Routine review of service gap reports with particular attention to availability of mental health services in rural communities, with development of services after a gap is identified. • Development of a plan to include consultation and technical assistance for pre-schools and other early-childhood programs. • Continue use of Block Grant funding to support services to homeless and transgender youth, and for early-intervention services.	• Mos. 6-12 • Mos. 9-12 • Mos. 0-12 • Mos. 0-12 • Mos. 0-12	• BCs; HFAA • CPDS; BCs; HFAA • CC; BCs; CRMS; CMD • CC; BCs; CPDS • CC; CCD; CRMS	• All relevant local community organizations identified; BCs presented to 85% of the identified groups. • Development begins. • 85% of children/youth residing in rural communities will be served without experiencing gaps in service. • Plan for consultation and technical assistance for pre-schools and other early-childhood programs is completed. • 85% of Block Grant performance measures will be achieved.
Goal 3: CAMHD and its provider agencies will consistently apply the current knowledge of evidence-based services in the development of individualized plans. The design of the mental health system will facilitate the application of these services. **3.1** *Achieve the widespread availability of evidence-based services* • Conduct training for providers in evidence-based services as identified by CAMHD/EBS. • Develop a network of trainers in evidence-based services. • Develop high quality training curricula and fact sheets regarding evidence-based services and best practices. • Provide training in evidence-based decision making for FGC Staff and prepare them for stakeholder	• Mos. 0-12 • Mos. 0-12 • Mos. 0-12	• CPDS • EBS Committee Chair; CPDS • EBS Committee Chair; CPDS	• 85% of CAMHD providers and FGC staff will receive training in relevant evidence-based services; 50% of trainers trained. • Evidence-based training curricula and fact sheets will be available. • FGC leadership will be trained and prepared to facilitate

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meetings to discuss evidence-based services and principles.			stakeholder meetings to discuss and clarify evidence-based decision-making; 50% of FGC staff trained and prepared.
• Assure monitoring protocols include evidence-based services and CASSP.	• Mos. 0-12	• CCD; CRES; CPM	• Monitoring protocols include evidence-based services and CASSP.
3.2 ***Establish*** *a mechanism for the ongoing evaluation of the use and effectiveness of evidence-based services.*			
• Completion of evaluation tools and strategies for measuring the use of evidence-based approaches, including monitoring protocols.	• Mos. 0-12	• EBS Committee Chair; CPDS	• Tools and strategies developed.
3.3 *Promote the sustained and appropriate application of evidence-based services and principles*			
• Develop fact sheets for relevant parties to make relevant knowledge available to address the needs of specific targeted populations.	• Mos. 0-12	• EBS Committee Chair; FGC Psychiatrists	• Fact sheets for all target populations developed.
• Conduct stakeholder meetings to promote understanding and appropriate use of evidence-based decision making. • Gather feedback from stakeholders about where evidence is absent or inaccessible for key decisions.	• Mos. 0-12	• EBS Committee Chair, BCs	• A representative from 55% of stakeholder agencies provides guidance about key areas that are lacking evidence to inform key decisions.

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Child and Adolescent Mental Health Division (CAMHD)
4-Year Strategic Plan
Management Plan for Year One

Goal 4: CAMHD and its provider agencies routinely evaluate performance data and apply the findings to guide management decisions and practice development.			
4.1 ***Expand*** *and improve the existing operational evaluation and supervision system based on routine practice measures and timely information that is increasingly clinically relevant and is readily exchanged in collaborative relationships with providers and partner agencies.*			
• Define a standard set of forms and reports that summarize relevant data in a clinically meaningful fashion and clarify relations between data gathering and decision-making.	• Mos. 0-12	• Network Committee; CMs; CRES; BCs; FGC CDs; FGC Supervisors	• Forms and Clinical Report Templates produced and approved; Decision-making guidelines developed.
• Develop CAMHMIS clinical/supervision module to implement data gathering and reporting.	• Mos. 0-12	• MIS	• Clinical module completed and operational.
• Sustain group and individual supervision, case presentations, monthly performance appraisals, individual supervision plans, and CSP audit tools as key supervision strategies.	• Mos. 0-12	• BCs	• 100% of staff with current ISPs; 100% of children and youth with current CSPs; and 85% compliance with CSP quality indicators.
• Maintain the care coordinators as the core mechanism for sharing information among child serving entities.	• Mos. 0-12	• BCs	• Decrease in missing data for multi-agency involvement fields in CAMHMIS.
4.2 ***A*** *clearly defined, decentralized, streamlined quality monitoring and improvement system that involves families, multiple agencies, and internal quality assurance personnel with clear direction for practice and policy decisions in the context of a knowledge-based learning organization.*			
• Develop operational definitions and procedures of monitoring components for FGCs, providers, internal reviews, and Central Office with input from key stakeholders.	• Mos. 0-12	• CPM; CPISC	• Development of review protocols for each monitoring component completed.
• Conduct in-depth reviews of FGC performance, provider performance and overall CAMHD	• Mos. 0-12	• CPM	• Annual reports completed in a timely fashion.

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performance measures. • Develop a plan to involve families in evaluation and performance management reviews.	• Mos. 0-12	• CPM	• Family participation procedures specified in monitoring protocols.
4.3 *Stakeholder* *communications that tell our story of success in a user-friendly, digestible and inspirational fashion to professional, legislative, community, and family groups and incorporates their feedback in measure selection, data interpretation and system design.*			
• Produce daily reports for frontline use and more user-friendly summary reports and newsletters, and provide additional professional support.	• Mos. 0-12	• CRES; MIS; CCD	• Array of clinical summary reports available for retrieval on a daily basis.
• Develop a media plan • POS contract with a PR agency to provide technical assistance to CAMHD for marketing, including district newsletters.	• Mos. 0-12	• CAC; BCs; HFAA	• Newsletter, press releases, and media coverage developed.
• Revise annual summary report and solicit feedback about desired content from key stakeholders.	• Mos. 0-12	• CRES; BCs; HFAA; POS PR/Marketing contract	• Annual summary report revised.
• National presentations and publications build internal capacity through training and increased data availability, partner with external researchers.	• Mos. 0-12	• CRES; CCD; Families; BCs; University/Community College faculty and students	• Increase in # of published articles and national presentations.
Goal 5: The business practices implemented throughout CAMHD and its provider agencies ensure high quality and accountable operations.			
5.1 *All CAMHD staff need to understand their roles and responsibilities, scope of authority, and be held accountable for their performance.*			
• Conduct a detailed workflow analysis for CAMHD.	• Mos. 0-9	• CMs; BCs; CPS	• Workflow analysis completed.
• Develop a Staffing/Business Plan to address results of analysis, including discussion of relevant positions and position descriptions and any	• Mos. 9-12	• CMs; BCs; CPS; CPDS	• Staffing/Business Plan developed

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necessary supporting training requirements. • Update all relevant PDs. • Identify training needs tied to specific positions/functions and incorporate into CAMHD Training Plan. • Integration of HIPAA requirements into daily practice of CAMHD and its provider agencies. • Revision of all relevant P&Ps and development of new P&Ps where necessary. • Training of all CAMHD staff on all HIPAA-revised and newly developed, P&Ps. • Provision of consultative assistance to provider agencies as they work to become HIPAA compliant.	• Mos. 0-12	• CAMHD Internal HIPAA management team; BCs; QAS	• 100% of PDs will be updated where necessary. • Revision of the CAMHD Training Plan initiated. • CAMHD is HIPAA compliant. • All P&Ps revised and/or developed. • All CAMHD staff trained. • Provider agencies receive adequate consultative assistance.
5.2 *Consistent enforcement of fiscal management processes to ensure good business practice, fiscal responsibility, and system accountability.* • Appropriate facilitation and application of the competitive bid process whenever possible. • Implement the Utilization Management (UM) Plan to conduct targeted utilization review of most costly services. • Expansion of resources and service capacity. • Interaction and collaboration with Juvenile Justice System. • Consistent oversight of provider agencies. • FGC Psychiatrists/Clinical Directors co-manage cases at the higher hospital-based	• Mos. 0-12 • Mos. 0-12	• CCMS • CRMS; CMs; BCs; FGC Psychiatrists • CRMS; CMs; BCs; FGC Psychiatrists • FCLB • CRMS; CMs; BCs; FGC Psychiatrists • CRMS; CMs; BCs; FGC Psychiatrists	• Little to no appeals of RFP awards, or resolution of RFP appeals in CAMHD's favor by the SPO. • Consistent decrease in placements and length of stay in mainland placements, hospital-based residential placements, and out-of-home placements.

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residential level of care. • Regular review of established thresholds. • Assure that utilization and flow of youth moving to and from more intensive services are examined and monitored on an ongoing basis. • Development of clear protocols around the routing and review of the monthly *Summary of Services*. • Define the requirements necessary to automate CAMHD's accounting function to allow CAMHMIS to properly interface with DAGS accounting system. • Performance of semi-annual MHCC caseload analysis. • Fully implement PAS requirements for all CAMHD staff. • Consistent monitoring of compliance with each section/Branch budget.	• Mos. 0-12 • Mos. 0-9 • Mos. 0-12 • Mos. 0-12 • Mos. 8-12	• CRMS; CMs; BCs; FGC Psychiatrists • CRMS • MIS; CAC • MIS • PHAO V; BCs • CMs; CPS • CMs	• Protocol developed and implemented. • Requirement defined. • MHCC caseload analyzed two times in the year. • 100% of staff have updated/current PAS. • All sections within CAMHD are operating within their budgets.
5.3 *Implementation of a Strategic Management Information Systems Plan that will allow for identification of the appropriate systems direction for the CAMHD and how it can further utilize technologies to facilitate meeting its mission, goals, and objectives.* • Implementation of QUEST-required HIPAA modifications. • Implementation of HIPAA requirements that affect Provider Reporting and Billing system. • Workstation upgrades for FGCs and Central Office (hardware and software operating systems). • Installation of Secure Broadband networks that supports necessary communications. • Secure funding for these upgrades.	• Mos. 10-12 • Mos. 0-8 • Mos. 0-10	• MIS • MIS • CC; CAC; MIS	• Full implementation of QUEST-required HIPAA modifications. • CAMHMIS is HIPAA compliant. • Required funding secured; Secure Broadband network installed; All FGC and Central Office workstations upgraded.

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• Consistent fiscal year systems maintenance and modifications on an annual basis.	• Mos. 0-12 • Mos. 0-12	• PHAO V; BCs	• CAMHMIS is current and updated to match the existing needs prior to the beginning of the new fiscal year.
• Development of a Clinical Supervision module to promote greater capacity and enhance performance of the CAMHD provider network.	• Mos. 4-12	• MIS; CCD; CRES	• Completion and implementation of the Clinical Supervision Module.

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Child and Adolescent Mental Health Division (CAMHD)
4-Year Strategic Plan
Management Plan for Year Two

IMPLEMENTATION STRATEGY	TIMETABLE	RESPONSIBILITY	PERFORMANCE MEASURES
Goal 1: There is shared ownership of the CAMHD vision, mission, initiatives, and achieved outcomes.			
1.1 *All child-serving entities have a clear understanding of, and commitment to, each other's roles and responsibilities in addition to their own:*			
• Facilitation of an agreement upon joint outcome measures amongst members of the leadership framework.	• Mos. 13-24	• CRES; BCs; HFAA;	• Joint outcome measure agreed upon.
• Facilitation the establishment of baseline protocol for resolving inter-agency disputes and then modifies to be responsive to each community's characteristics.	• Mos. 13-18	• CC; BCs; HFAA	• Protocol are developed and implemented at the state and community level.
1.2 *There will be adequate resources available for all child-serving entities in order to meet their statutory mandates.*			
• Support the completion of statutory updates for all child-serving entities in the state.	• Mos. 13-24	• CP	• All statutes are updated.
• Continue to maximize federal grant and other reimbursement opportunities.	• Mos. 13-24	• CFRDS; New full time grant writer	• Increase in percentage of overall resources available to CAMHD that are obtained through federal grant and similar funding opportunities.
• Continue to update and keep current our understanding of what services are empirically supported.	• Mos. 13-24	• EBS Committee Chair	• The integration of evidence-based services continues, and the system's understanding of what services are evidence-based, is current and continues to be revised according to current research.
1.3 *Improvement in the active engagement of, and communication with, families and community organizations invested in the system of care:*			
• Increase public awareness of the system's	• Mos. 13-24	• All CAMHD staff; HFAA;	• Increase in public newsletters,

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accomplishments. • Newsletter • Television Ads/Public Service Announcements • Public "Thank You's"		SMHC	ads, PSAs.
• Nurture an environment where families and community stakeholders are actively and fully engaged in the process as partners.	• Mos. 13-24	• All CAMHD staff; HFAA	• Increase in family satisfaction and participation in the process, as measured by revised Family Satisfaction Surveys.
1.4 *Increased collaboration with Hawaii's university and community college institutions in training students in CASSP principles, EBS, and the evaluation manner of thinking.*			
• Offer to guest lecture in classrooms.	• Mos. 13-24	• CPDS	• Offers made.
• Continued collaboration to ensure that mini-modules of various EBS services are updated as necessary.	• Mos. 13-24	• CPDS	• All mini-modules contain current EBS information.
Goal 2: The CAMHD and its providers will consistently adhere to the Hawaii CASSP principles.			
2.1 *Create a community-based, accessible system of care through which families are guided by knowledgeable and experienced veteran staff.*			
• Educate, train and inform CAMHD stakeholders and families to understand populations served by CAMHD and the context of CASSP.	• Mos. 13-24	• All CAMHD staff w/contact with public; FGCs; HFAA	• Occurs at 100% of FGC community presentations.
• Research catalogues of formal and informal resources/supports currently available in the communities and through partner agencies/entities.	• Mos. 13-24	• BCs; CMs; HFAA	• Hard copies of catalogues made available in each FGC, for each PP, and for HFAA.
• Train all CAMHD staff to know and understand populations served and context of CASSP principles.	• Mos. 13-24	• CMs; CPDS; BCs; HFAA	• 90% of staff receive information; 90% trained; 100% of attendance documented.
• Collect information on consumer satisfaction with	• Mos. 13-24	• CRES; HFAA	• Data collected quarterly; annual

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the system, inclusive of CAMHD, regarding implementation of CASSP principles.			report made available.
• Continued integration of CASSP principles into supervision of care coordination.	• Mos. 13-24	• MHS-1s	• Integration continued.
• Expand HFAA/PP role at each FGC and across stakeholder lines to guide families.	• Mos. 18-24	• CMs; BCs; HFAA	• 75% of PP positions filled; 100% of families made aware of the availability of their PP at intake.
• Develop statewide resource catalogue by geographic areas.	• Mos. 13-24	• CMs; BCs; HFAA	• 50% complete.
• Implementation of the Strategic Plan developed in Year 1 to address full continuum of mental health services for youth involved in the juvenile justice system.	• Mos. 13-24	• CC; FCLB	• All youth in the juvenile justice system receiving needed mental health services.
2.2 *Ongoing education and public relations effort to broaden and improve attitudes, understanding and acceptance of families of children/youth with mental health needs.*			
• Co-training with FGC staff and HFAA on de-stigmatizing children's mental health, CASSP and related topics.	• Mos. 13-24	• CPDS; FGC Management Team; HFAA	• 2 co-trainings scheduled and conducted by each FGC; Flyers advertising training for each FGC.
• Continued distribution of family/public friendly literature that includes behavioral/functional examples for each CASSP principle.	• Mos. 13-24	• FGC Management Team; CPM; CPDS	• 100% distribution to individuals listed in the distribution plan.
• Conduct self-assessment of attitudes of FGC staff, partners and community members towards families w/mental health needs.	• Mos. 13-24	• FGC Management Team; CRES	• Tool developed and self-assessment conducted with 85% of FGC staff; Tool implemented with 2 key partners per FGC; Tool implemented by one community group per FGC.
• Implement a research study on results of self-assessment.	• Mos. 13-24	• FGC Management Team; CRES	
2.3 *Increase broader community involvement and development of resources to support children and youth and*			

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their families.			
• Promote CSP and strengths-based planning model through training and mentoring.	• Mos. 13-24	• All CAMHD staff; HFAA	• 85% compliance with CSP quality indicators.
• Continue to strongly support and promote youth participation in the planning process.	• Mos. 13-24	• All CAMHD staff; HFAA	• 85% of youth participating in the CSP process statewide; 80% of youth participating satisfied with services (Youth Satisfaction Survey).
• Continue to participate in community-based organizations (i.e. Rotary, Chamber of Commerce, etc.).	• Mos. 13-24	• BCs	• BCs present to 85% of identified gorup.
• Peer education/mentoring/tutoring. Each FGC to develop a program in partnership with a community organization.	• Mos. 13-24	• CPDS; BCs	• Each FGC has develop a program in partnership that addresses recruitment of teens as peer tutors/mentors; Each FGC has an MOA with 2 community organizations.
• Support local naturally occurring community-based after school/weekend programs that will assist youth in transitioning to adulthood. Focus on self-determination, independent living skills, work readiness and pre-vocational skills.	• Mos. 13-24	• CMs; HFAA; YC; BCs	• Support provided.
• Routine review of service gap reports with particular attention to availability of mental health services in rural communities, with development of services after a gap is identified.	• Mos. 13-24	• CC; BCs; CRMS; CMD	• 85% of children/youth residing in rural communities will be served without experiencing gaps in service.
• Implementation of the plan developed in Year 1 to include consultation and technical assistance for pre-schools and other early-childhood programs.	• Mos. 13-24	• CC; BCs; CPDS	• Plan for consultation and technical assistance for pre-schools and other early-childhood programs is implemented.
• Continue use of Block Grant funding to support services to homeless and transgender youth, and for	• Mos. 13-24	• CC; CCD; CRMS	• 85% of Block Grant performance measures will be achieved.

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early-intervention services.			
Goal 3: CAMHD and its provider agencies will consistently apply the current knowledge of evidence-based services in the development of individualized plans. The design of the mental health system will facilitate the application of these services.			
3.1 *Achieve the widespread availability of evidence-based services: Implementation*			
• Develop care coordination supervision model and provide training to MHS-1s on how to supervise MHCCs use of evidence-based decision-making and best practices for care coordination.	• Mos. 13-24	• CPDS	• A care coordination supervision model developed and 85% of MHS-1s trained on the use of it.
• Develop Provider Supervision model and provide training to agencies on how to supervise the use of evidence-based services.	• Mos. 13-24	• CPDS; EBS Committee Chair	• Provider Supervision model developed and 75% of agencies are trained on the use of it.
• Develop a network of trainers in evidence-based services.	• Mos. 13-24	• CPDS	• Network of individuals will be identified to become trainers with at least one trainer per evidence-based services track.
3.2 *Establish a mechanism for the ongoing evaluation of the use and effectiveness of evidence-based services.*			
• Assess impact of current practice on family and provider satisfaction through Provider Satisfaction Survey and Family Satisfaction Survey.	• Mos. 13-24	• CCD; HFAA; MIS; CAMHD providers	• For each survey, data from 20% of registered CAMHD population will be gathered.
• Assess impact of current practice on outcomes, and utilization patterns.	• Mos. 13-24	• CCD; MIS; CRES	• Data gathered from 65% of the CAMHD registered population.
3.3 *Promote the sustained and appropriate application of evidence-based services and principles*			
• Continue to conduct stakeholder meetings to promote understanding and appropriate use of evidence-based decision making and continue to gather feedback from stakeholders about where evidence is absent or inaccessible for key decisions.	• Mos. 13-24	• EBS Committee Chair; FGC Psychiatrists	• Representatives from 65% of stakeholder agencies participating and 65% of them providing feedback.
• Begin to convene meetings to coordinate incentives for evidence-based services as part of system	• Mos. 13-24	• CMs	• Complete design protocol.

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design.			
Goal 4: CAMHD and its provider agencies routinely evaluate performance data and apply the findings to guide management decisions and practice development. **4.1** *Expand and improve the existing operational evaluation and supervision system based on routine practice measures and timely information that is increasingly clinically relevant and is readily exchanged in collaborative relationships with providers and partner agencies.*			
• Sustain group and individual supervision, case presentations, monthly performance appraisals, individual supervision plans, and CSP audit tools as key supervision strategies.	• Mos. 13-24	• BCs	• 100% of staff with current ISPs; 100% of children and youth with current CSPs; and 85% compliance with CSP quality indicators; 90% completed CAFAS, CALOCUS, and Achenbach CBCL parent data quarterly; improved outcomes on these measures.
• Provide training and technical assistance on clinical processes and clinical/supervision module.	• Mos. 13-24	• CPDS; BCs; FGC Psychiatrists	• Improve training evaluation ratings; increase in # of clinical module reports accessed.
• Maintain care coordinators as the core mechanism for sharing information among child-serving entities.	• Mos. 13-24	• BCs	• Decrease in missing data for multi-agency involvement fields in CAMHMIS.
• Establish or maintain a mechanism for local level interagency management discussion in each district.	• Mos. 13-24	• CC; BCs	• Increase in # of child-serving entities participating in local level inter-system management discussions.
4.2 *A clearly defined, decentralized streamlined quality monitoring and improvement system that involves families, multiple agencies, and internal quality assurance personnel*			

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with clear implications for practice and policy decisions in the context of a knowledge-based learning organization.			
• Implement a plan to involve families in evaluation and performance management reviews.	• Mos. 13-24	• CPM; HFAA	• Increase in the # of family members involved in the review and evaluation process.
• Sustain provider and Central Office reviews at the State level.	• Mos. 13-24	• CPM; CPISC	• Annual reports completed that describe level of performance to guide decentralization.
• Conduct review of FGCs by Central Office.	• Mos. 13-24	• CPM	• Annual reports completed that describe level of performance to guide decentralization.
• Refine monitoring protocols as needed.	• Mos. 13-24	• CPM	• Protocols are revised as needed.
• Explore agreements for interagency monitoring.	• Mos. 13-24	• CC; CPM	• Completed workplan for interagency discussion regarding integrated monitoring.
• Move to internal case-based reviews for provider agencies/less external monitoring based on performance and self-monitoring.	• Mos. 13-24	• CPM	• Increase in the # of provider agencies conducting internal monitoring using case-based reviews.
• Develop capacity to perform and support special, controlled studies in local areas, including evaluation of prevention, specific populations, and longer-term follow-up.	• Mos. 13-24	• PA; Community representatives; Research professionals; CRES	• Special study and evaluation reports completed and appropriately distributed.
4.3 *Stakeholder communications that tell our story of success in a user-friendly, digestible and inspirational fashion to professional, legislative and family groups and incorporate their feedback in measure selection, data interpretation and system design.*			
• Continue to build internal capacity to present and publish on a local and national level through training and increased data availability, partner with external researchers.	• Mos. 13-24	• CRES; CCD; Families; BCs; University/Community College faculty and students	• Increase in # of published articles and presentations.

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Child and Adolescent Mental Health Division (CAMHD)
4-Year Strategic Plan
Management Plan for Year Two

Goal 5: The business practices implemented throughout CAMHD and its provider agencies ensure high quality and accountable operations.			
5.1 *All CAMHD staff need to understand their roles and responsibilities, scope of authority, and be held accountable for their performance.*			
• Update and revise the CAMHD employee handbook.	• Mos. 13-18	• CPS	• Employee handbook revised.
• Develop an orientation and expanded mentoring program.	• Mos. 19-24	• CPS; BCs; CPDS	• Orientation program/plan developed and implemented.
• Develop in-service training courses targeted towards major portion of CAMHD staff.	• Mos. 13-18	• CPDS	• In-service training course curriculum developed and initial trainings have begun.
• Integration of HIPAA requirements into daily practice of CAMHD. • Monitoring of compliance efforts.	• Mos. 13-24	• CMs; QAS; MIS; CPISC; • CAMHD Internal HIPAA management team.	• HIPAA compliance.
• Provision of in-service training courses for all of CAMHD staff.	• Mos. 19-24	• CPDS	• 100% of CAMHD staff have received appropriate trainings.
5.2 *Consistent enforcement of fiscal management processes to ensure good business practice, fiscal responsibility, and system accountability.*			
• Compliance program with comprehensive claims review and post-review analysis is completed.	• Mos. 13-18	• CAMHD Compliance Officer; CAMHD PHAO V	• Analysis completed and recommendations implemented.
• Appropriate facilitation and application of the competitive bid process whenever possible.	• Mos. 13-24	• CCMS	• Little to no appeals of RFP awards or resolution of RFP appeals in CAMHD's favor by the SPO.
• Implement the Utilization Management (UM) Plan to conduct targeted utilization review of most costly services.	• Mos. 13-24	• CRMS; CMs; BCs	• Consistent decrease in placements and length of stay in mainland, hospital-based residential, out-of-home placements.

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• Expansion of resources and service capacity.	• Mos. 13-24	• CRMS; CMs; BCs; FGC Psychiatrists	
• Interaction and collaboration with Juvenile Justice System.	• Mos. 13-24	• CRMS; CMs; BCs; FGC Psychiatrists	
• Consistent oversight of provider agencies.	• Mos. 13-24	• CRMS; CMs; BCs; FGC Psychiatrists	
• FGC Psychiatrists co-manage cases at the higher hospital-based residential level of care.	• Mos. 13-24	• CRMS; CMs; BCs; FGC Psychiatrists	
• Regular review of established thresholds.	• Mos. 13-24	• CRMS; CMs; BCs; FGC Psychiatrists	
• Timely completion of monthly *Summary of Services*.	• Mos. 13-24	• MIS; CAMHD PHAO V	• *Summary of Services* timely.
• Completion and implementation of CAMHD automated accounting function to allow CAMHMIS to properly interface with DAGS accounting system.	• Mos. 13-24	• MIS	• CAMHD automated accounting function completed and implemented.
• Performance of semi-annual MHCC caseload analysis.	• Mos. 13-24	• PHAO V; BCs	• MHCC caseload analyzed twice a year.
• Fully implement PAS requirements for all CAMHD.	• Mos. 13-24	• CMs; BCs	• 100% of CAMHD staff have updated/current PAS.
• Strict internal adherence to 30-day reimbursement goal.	• Mos. 13-24	• CAMHD PHAO V; MIS	• Decrease in amount of 30-day reimbursement goals missed.
• Consistent monitoring of compliance with each sectional budget.	• Mos. 13-24	• CMs	• All sections within CAMHD are living within their budgets.
• Completion of billing pre-screen edits.	• Mos. 19-24	• CAMHD PHAO V; CCRU	• 75% of claims reviewed are acceptable.
• Claim audits performed based on a random sample of all claims submitted during the fiscal year, and results will be extrapolated to the full set of claims.	• Mos. 19-24	• CAMHD Compliance Officer; CAMHD PHAO V; CCRU	• Reduction in CAMHD overpayment to agencies; No successful challenges to the random sampling methodology through the CAMHD appeals process or through other formal processes.

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5.3 *Implementation of a Strategic Management Information Systems Plan that will allow for identification of the appropriate systems direction for the CAMHD and how it can further utilize technologies to facilitate meeting its mission, goals, and objectives.*			
• Website is regularly updated with updated information, news, documents for publishing, and other information for public access.	• Mos. 13-24	• MIS	• Website is current, user-friendly, and accessible.

• Comprehensive computer training of CAMHD staff.
  • Orientation to CAMHMIS and email for new users.
  • Oracle Discoverer Training for all users.
  • Microsoft Word training for new users.
  • Microsoft Excel training for specialty users.
  • Microsoft Access training for interested specialty users.
  • Clinical Module training.
  • Training on new modules as developed.
	• Mos. 13-24	• MIS	• Improvement of CAMHD staff competency in all defined areas; Decrease in requests for MIS assistance in these areas.

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Child and Adolescent Mental Health Division (CAMHD)
4-Year Strategic Plan
Management Plan for Year Three

IMPLEMENTATION STRATEGY	TIMETABLE	RESPONSIBILITY	PERFORMANCE MEASURES
Goal 1: There is shared ownership of the CAMHD vision, mission, initiatives, and achieved outcomes.			
1.1 *All child-serving entities have a clear understanding of, and commitment to, each other's roles and responsibilities in addition to their own:*			
• Invite all stakeholders to participate in presentations regarding improvements in CAMHD management values and practices.	• Mos. 25-36	• All stakeholders; leadership framework; HFAA; SMHC; community organizations.	• Joint performance presentations conducted.
• Training and mentoring at the community/local level**,** monitoring of processes and outcomes, and revisions of developed tools, protocols and measures will occur as necessary.	• Mos. 25-36	• CPDS; CRES; BCs; HFAA	• Training and mentoring provided; Consistent monitoring; All tools, protocol, and joint outcome measures are current.
1.2 *There will be adequate resources available for all child-serving entities in order to meet their statutory mandates.*			
• Continued maximization of federal grant and other reimbursement opportunities.	• Mos. 25-36	• State agency grant writers	• Increase in amount of federal funding opportunities received.
• Continued integration of EB services into the system of care.	• Mos. 25-36	• EBS Committee Chair	• Integration continues, and the system's understanding of what services are evidence-based, is current and continues to be revised according to current research.
1.3 *Improvement in the active engagement of, and communication with, families and community organizations invested in the system of care:*			

• Increase public awareness of the system's accomplishments.
  • Newsletter
  • Television Ads/Public Service Announcements
  • Public "Thank You's"
	• Mos. 25-36	• All of CAMHD staff; HFAA	• Increase in # of public news articles, ads, and PSAs.

• Continue to nurture an environment where families	• Mos. 25-36	• All of CAMHD staff;	• Increase in family satisfaction as

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and community stakeholders are actively and fully engaged in the process as partners, and that there is shared ownership amongst CAMHD families and community stakeholders.		HFAA	measured by revised Family Satisfaction Surveys.
1.4 *Increased collaboration with Hawaii's university and community college institutions in training students in CASSP principles, EBS, and an evaluative manner of thinking.*			
• Continue to offer to guest lecture in classrooms.	• Mos. 25-36	• CPDS	• Offers made.
• Continued collaboration to ensure that mini-modules of various EBS services are updated as necessary.	• Mos. 25-36	• CPDS	• All mini-modules contain current EBS information.
Goal 2: The CAMHD and its providers will consistently adhere to the Hawaii CASSP principles.			
2.1 *Local based open access system where families are guided through by knowledgeable and experienced veteran staff.*			
• Continue to train all CAMHD staff on the CAMHD populations served and the context of CASSP within the system of care. • Provide teaching tools w/examples of populations served and application of CASSP to all staff.	• Mos. 25-36	• CMs; CPDS; BCs; HFAA	• 90% of staff receive information; 90% trained; 100% of attendance documented.
• Continue to collect information on consumer satisfaction with how CAMHD and other stakeholders are applying Hawaii's CASSP principles.	• Mos. 25-36	• CRES; HFAA	• Data collected quarterly; annual report made available to the public.
• Continue to expand HFAA/PP role at each FGC and across stakeholder lines to guide families.	• Mos. 25-36	• CMs; BCs; HFAA	• 95% of PP positions filled; 85% of families have PP contact; 75% of families have joint PP and MHCC contact.

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• Complete the development of a statewide resource catalogue by geographic areas.	• Mos. 25-30	• CMs; BCs; HFAA	• 100% complete.
• Implement the developed PP/FGC team to maximize natural supports/resources and/or facilitate access to formal services as needed.	• Mos. 25-36	• BCs; HFAA	• 90% increase in use of natural supports as evidenced in CSP audits; 85% of CAMHD children/youth served in-home.
• Implementation of the Strategic Plan developed in Year 1 to address full continuum of mental health services for youth involved in the juvenile justice system.	• Mos. 25-36	• CC; FCLB	• All youth in the juvenile justice system receiving needed mental health services.
2.2 *Ongoing education and public relations effort to broaden and improve attitudes, understanding and acceptance of families of children with mental health needs.*			
• Co-training with FGC staff and HFAA on de-stigmatizing children's mental health, CASSP and related topics.	• Mos. 25-36	• CPDS; FGC Management Team; HFAA	• 2 co-trainings scheduled and conducted by each FGC; Flyers advertising training for each FGC.
• Distribution of family/public friendly literature which includes behavioral/functional examples for each CASSP principle.	• Mos. 25-36	• FGC Management Team; CPM; CPDS	• 100% distribution to each individual listed in the distribution plan.
2.3 *Increase broader community involvement and development of resources to support children and youth and their families.*			
• Promote CSP and strengths-based planning model through training and mentoring.	• Mos. 25-36	• All CAMHD staff; HFAA	• 85% compliance with CSP quality indicators.
• Strongly support and promote youth participation in planning.	• Mos. 25-36	• All CAMHD staff; HFAA	• 85% of youth participating in the CSP process statewide; 80% of youth participating satisfied with services (Youth Satisfaction Survey).
• Participate in community-based organizations (i.e. Rotary, Chamber of Commerce, etc.).	• Mos. 25-36	• BCs	• BCs presented to 85% of identified groups.
• Peer education/mentoring/tutoring.	• Mos. 25-36	• BCs	• Each FGC has developed a

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			program in partnership with a community organization; Program description and MOA addresses recruitment of teens as peer tutors/mentors.
• Support local naturally occurring community-based after school/weekend programs that will assist youth in transitioning to adulthood. Focus on self-determination, independent living skills, work readiness and pre-vocational skills.	• Mos. 25-36	• CMs; HFAA; YC; BCs	• Each FGC has an MOA with 2 community organizations to support these programs.
• Conduct demonstration program and follow-up study of youth in local naturally occurring community-based programs developed in Year 2.	• Mos. 25-36	• CMs; HFAA; YC; FGC Management Teams	• Data collected quarterly, regarding # and % of youth employed or in higher education/training programs post-discharge.
• Develop a "Kids Helping Kids" youth warm line.	• Mos. 25-36	• CMs; HFAA; YC	• Implementation plan developed.
• Routine review of service gap reports with particular attention to availability of mental health services in rural communities, with development of services after a gap is identified.	• Mos. 25-36	• CC; BCs; CRMS; CMD	• 85% of children/youth residing in rural communities will be served without experiencing gaps in service.
• Implementation of the plan developed in Year 1 to include consultation and technical assistance for pre-schools and other early-childhood programs.	• Mos. 25-36	• CC; BCs; CPDS	• Plan for consultation and technical assistance for pre-schools and other early-childhood programs is implemented.
• Continue use of Block Grant funding to support services to homeless and transgender youth, and for early-intervention services.	• Mos. 25-36	• CC; CCD; CRMS	• 85% of Block Grant performance measures will be achieved.
Goal 3: CAMHD and its provider agencies will consistently apply the current knowledge of evidence-based services in the development of individualized plans. The design of the mental health system will facilitate the			

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application of these services. **3.1** *Achieve the widespread availability of evidence-based services*			
• Continue to conduct training for providers and FGC staff in evidence-based services as identified by CAMHD/EBS.	• Mos. 25-36	• CPDS	• 85% providers and CAMHD staff trained.
• Continue to develop a network of trainers in evidence-based services.	• Mos. 25-36		• One EBS trainer per track whose training services are available to providers.
• Provide training in evidence-based decision making for FGC staff and prepare them for stakeholder meetings to discuss evidence-based services and principles.	• Mos. 25-36	• EBS Committee Chair; CPDS	• 85% trained and prepared to lead stakeholder discussions; a representative of 75% of stakeholder agencies participate.
3.2 *Establish a mechanism for the ongoing evaluation of the use and effectiveness of evidence-based services..*			
• Continue to assess impact of current practice on outcomes, and utilization patterns.	• Mos. 25-36	• CCD; HFAA; MIS; CAMHD providers	• For each survey, data from 30% of CAMHD registered population will be gathered.
• Conduct review of local evidence of practice impact via established mechanisms through MIS.	• Mos. 25-36	• CCD; MIS; CRES	• Data gathered for review from 65% of the CAMHD registered population.
3.3 *Promote the sustained and appropriate application of evidence-based services and principles.*			
• Continue to conduct stakeholder meetings to promote understanding and appropriate use of evidence-based decision making and continue to gather feedback from stakeholders about where evidence is absent or inaccessible for key decisions.	• Mos. 25-36	• CCD; EBS Committee Chair; CRES	• Representatives from 75% of stakeholders agencies participate and 75% will provide feedback.
• Disseminate first review locally and nationally.	• Mos. 25-36	• EBS Committee Chair; FGC Psychiatrists	• Publications and presentations submitted/conducted.
Goal 4: CAMHD and its provider agencies routinely evaluate performance data and apply the findings to guide management decisions and practice development.			

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Child and Adolescent Mental Health Division (CAMHD)
4-Year Strategic Plan
Management Plan for Year Three

4.1 *Expand and develop an operational evaluation and supervision system based on routine practice measures and timely information that is increasingly clinically relevant and is really exchanged in collaborative relationships with providers and partner agencies.*			
• Sustain group and individual supervision, case presentations, monthly performance appraisals, individual supervision plans, and CSP audit tools as key supervision strategies.	• Mos. 25-36	• CCD; EBS Committee Chair; CRES	• 100% of staff with current ISPs; 100% of children and youth with current CSPs; and 85% compliance with CSP quality indicators.
• Establish or maintain a mechanism for local level interagency management discussion in each district.	• Mos. 25-36	• BCs	• Increase in # of child-serving entities participating in local level inter-system management discussions.
• Provide on-going support and technical assistance on clinical processes and clinical/supervision module.	• Mos. 25-36	• CC; MIS	• Increase in # of clinical reports accessed; increasing trend in user satisfaction.
• Monitoring and assessment of clinical processes and clinical/supervision module adherence.	• Mos. 25-36	• CCD; CPM; BCs; QAS	• Increase in # of clinical reports accessed and increasing trend in user satisfaction.
• Support electronic sharing including ISPED, descriptions of joint data sets, and system requirements.	• Mos. 25-36	• CC; MIS	• Multi-agency reports developed.
4.2 *A clearly defined, decentralized streamlined quality monitoring and improvement system that involves families, multiple agencies, and internal quality assurance personnel with clear implications for practice and policy decisions in the context of a knowledge-based learning organization.*			
• Sustain family involvement in evaluation and performance management reviews.	• Mos. 25-36	• CPM; HFAA	• Increase in the # of family members involved in the review and evaluation process.

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• Sustain provider and Central Office reviews at the State level.	• Mos. 25-36	• CPM; CPISC	• Annual reports completed in a timely fashion
• Refine monitoring protocols as needed.	• Mos. 25-36	• CPM	• Protocols are revised as needed.
• Develop capacity to perform and support special, controlled studies in local areas, including evaluation of prevention, specific populations, and longer-term follow-up.	• Mos. 25-36	• Leadership framework; Community representatives; Research professionals; CRES	• Special study and evaluation reports completed.
• FGC reviews accomplished through internal reviews and internal monitoring.	• Mos. 25-36	• BCs; QAS	• Quarterly reports to Central Office.
• Central Office provides validation of internal reviews/FGC reviews and technical assistance/feedback based on a leveling system to determine extent of external monitoring needed.	• Mos. 25-36	• CPM; QAS	• FGC feedback report; Statewide aggregate reports.
• Move to internal case-based reviews for provider agencies/less external monitoring based on performance and self-monitoring.	• Mos. 25-36	• CPM	• Increase in the # of provider agencies conducting internal monitoring using case-based reviews.
4.3 *Stakeholder communications that tell our story of success in a user-friendly, digestible and inspirational fashion to professional, legislative and family groups and incorporate their feedback in measure selection, data interpretation and system design.*			
• Build internal capacity to present and publish on a national level through training and increased data availability, partner with external researchers.	• Mos. 25-36	• CRES; CCD; Families; BCs; University and Community College faculty and students	• Increase in # of publications and presentations.
Goal 5: The business practices implemented throughout CAMHD and its provider agencies ensure high quality and accountable operations.			
5.1 *All CAMHD staff need to understand their roles and responsibilities, scope of authority, and be held accountable for their performance.*			
• Continued integration of HIPAA requirements into	• Mos. 25-36	• CMs; QAS; MIS; CPISC	• HIPAA compliance.

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daily practice of CAMHD and its provider agencies. • Monitoring of compliance efforts.			
• Provision of in-service training courses for all of CAMHD staff.	• Mos. 25-36	• CPDS	• 100% of CAMHD staff have received appropriate trainings.
5.2 *Consistent enforcement of fiscal management processes to ensure good business practice, fiscal responsibility, and system accountability.*			
• Appropriate facilitation and application of the competitive bid process.	• Mos. 25-36	• CCMS	• Little to no appeals of RFP awards or resolution of RFP appeals in CAMHD's favor by the SPO.
• Implement the Utilization Management (UM) Plan to conduct targeted utilization review of most costly services.	• Mos. 25-36	• CRMS; CMs; BCs; FGC Psychiatrists	• Consistent decrease in placements and length of stay in mainland placements, hospital-baSEBD residential placements, and out-of-home placements.
• Expansion of resources and service capacity.	• Mos. 25-36	• CRMS; CMs; BCs; FGC Psychiatrists	
• Interaction and collaboration with Juvenile Justice System.	• Mos. 25-36	• CRMS; CMs; BCs; FGC Psychiatrists	
• Consistent oversight of provider agencies.	• Mos. 25-36	• CRMS; CMs; BCs; FGC Psychiatrists	
• FGC Psychiatrists/Clinical Directors co-manage cases at the higher hospital-based residential level of care.	• Mos. 25-36	• CRMS; CMs; BCs; FGC Psychiatrists	
• Regular review of established thresholds.	• Mos. 25-36	• CRMS; CMs; BCs, FGC Psychiatrists	
• Completion of monthly *Summary of Services*.	• Mos. 25-36	• MIS; CAMHD PHAO V	• *Summary of Services* timely.
• Performance of semi-annual MHCC caseload analysis.	• Mos. 25-36	• PHAO V; BCs	• MHCC caseload analyzed twice a year.
• Fully implement PAS requirements for all CAMHD.	• Mos. 25-36	• CMs; BCs	• 100% of CAMHD staff have updated/current PAS.
• Strict internal adherence to 30-day reimbursement goal.	• Mos. 25-36	• CAMHD PHAO V; MIS	• Decrease in amount of 30-day reimbursement goals missed.

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• Consistent monitoring of compliance with each sectional budget.	• Mos. 25-36	• CMs	• All sections within CAMHD are operating within their budgets.
• Claims audits will be performed based on random sample of all claims submitted during the fiscal year, and results will be extrapolated to the full set of claims.	• Mos. 25-36	• CAMHD Compliance Officer; CAMHD PHAO V; CCRU	• Reduction in CAMHD overpayments to providers; No successful challenges to random sampling methodology through the CAMHD appeals process or other formal processes.
5.3 *Implementation of a Strategic Management Information Systems Plan that will allow for identification of the appropriate systems direction for the CAMHD and how it can further utilize technologies to facilitate meeting its mission, goals, and objectives.*			
• Website is regularly updated with updated information, news, documents for publishing, and other information for public access.	• Mos. 25-36	• MIS	• Website is current, user-friendly, and accessible.
• Comprehensive computer training of CAMHD staff. • Orientation to CAMHMIS and email for new users. • Oracle Discoverer Training for all users. • Microsoft Word training for new users. • Microsoft Excel training for specialty users. • Microsoft Access training for interested specialty users. • Clinical Module training. • Training on new modules as developed.	• Mos. 25-36	• MIS	• Improvement of CAMHD staff competency in all defined areas; Decrease in requests for MIS assistance in these areas.

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Child and Adolescent Mental Health Division (CAMHD)
4-Year Strategic Plan
Management Plan for Year Four

IMPLEMENTATION STRATEGY	TIMETABLE	RESPONSIBILITY	PERFORMANCE MEASURES
Goal 1: There is shared ownership of the CAMHD vision, mission, initiatives, and achieved outcomes.			
1.1 *All child-serving entities have a clear understanding of, and commitment to, each other's roles and responsibilities in addition to their own:*			
• Invite all stakeholders to participate in presentations regarding improvements in CAMHD management values and practices. • Training and mentoring at community/local level; Consistent monitoring; Revisions of above tools, protocols, and measures, as needed.	• Mos. 36-48	• All stakeholders; leadership framework; HFAA; SMHC; community organizations	• Joint performance presentations conducted. • Training and mentoring provided; Consistent monitoring conducted. • All tools, protocol, and joint outcome measures are current.
1.2. *There will be adequate resources available for all child-serving entities in order to meet their statutory mandates.*			
• Maximization of federal grant and other reimbursement opportunities.	• Mos. 36-48	• CFRDS; Grant writers	• Increase in maximization of federal funding opportunities.
• Integration of EB services into the system of care.	• Mos. 36-48	• EBS Committee Chair	• Integration continues and the system's understanding of what services are evidence-based is current and continues to be revised according to current research.
1.3 *Improvement in the active engagement of, and communication with, families and community organizations invested in the system of care:*			

• Continue efforts to increase public awareness of the system's accomplishments.
  • Newsletter
  • Television Ads/Public Service Announcements
  • Public "Thank You's"
	• Mos. 36-48	• All of CAMHD staff; HFAA	• Continued efforts through public news articles, ads, PSA's.

• Continue to nurture environment where families and community stakeholders are actively and fully	• Mos. 36-48	• All of CAMHD staff; HFAA	• Increase in family satisfaction and true participation in the

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engaged in the process as partners, and that there is shared ownership amongst CAMHD families and community stakeholders.			process, as measured by revised Family Satisfaction Surveys.
1.4 *Increased collaboration with Hawaii's university and community college institutions in training students in CASSP principles, EBS, and the evaluation manner of thinking.*			
• Offer to guest lecture in classrooms.	• Mos. 36-48	• CPDS	• The children's mental health workforce including both FGC staff and providers, will have clear understanding of EBS and how to utilize.
• Continued collaboration to ensure that mini-modules of various EBS services are updated as necessary.	• Mos. 36-48	• CPDS	• All mini-modules contain current EBS information.
Goal 2: The CAMHD and its providers will consistently adhere to the Hawaii CASSP principles.			
2.1 *Maintain and improve the community-based, accessible system of care through which families are guided by knowledgeable and experienced veteran staff.*			
• Train all CAMHD staff to know and understand populations served and context of CASSP within the system of care. • Provide teaching tools w/examples of populations served and application of CASSP to all staff.	• Mos. 36-48	• CMs; CPDS; BCs; HFAA	• 90% of staff receive information; 90% trained; 100% of attendance documented.
• Collect information on consumer satisfaction with CASSP.	• Mos. 36-48	• CRES; HFAA	• Data collected quarterly; annual report made available.
• Implement the developed PP/FGC team to maximize natural supports/resources and/or facilitate access to formal services as needed.	• Mos. 36-48	• BCs; HFAA	• 90% increase in use of natural supports as evidenced in CSP audits; 85% of CAMHD children/youth served in-home.
• Implementation of the Strategic Plan developed in	• Mos. 36-48	• CC; FCLB	• All youth in the juvenile justice

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Year 1 to address full continuum of mental health services for youth involved in the juvenile justice system.			system receiving needed mental health services.
2.2 *Ongoing education and public relations effort to broaden and improve attitudes, understanding and acceptance of families with mental health needs.*			
• Co-training with FGC staff and HFAA on de-stigmatizing children's mental health, CASSP and related topics.	• Mos. 36-48	• CPDS; FGC Management Team; HFAA	• 2 co-trainings scheduled and conducted by each FGC; Flyers advertising training for each FGC.
• Distribution of family/public friendly literature which includes behavioral/functional examples for each CASSP principle.	• Mos. 36-48	• FGC Management Team; CPM; CPDS	• 100% distribution to individuals listed in distribution plan.
2.3 *Increase broader community involvement and development of resources to support children and youth and their families.*			
• Promote CSP and strengths-based planning model through training and mentoring.	• Mos. 36-48	• All CAMHD staff; HFAA	• 85% overall on quality review statewide.
• Strongly support and promote youth participation in planning.	• Mos. 36-48	• All CAMHD staff; HFAA	• 85% of youth participating in the CSP process statewide; 80% of youth participating satisfied with services (Youth Satisfaction Survey).
• Participate in community-based organizations (i.e. Rotary, Chamber of Commerce, etc.).	• Mos. 36-48	• BCs	• BCs present to 85% of identified groups.
• Support local naturally occurring community-based after school/weekend programs that will assist youth in transitioning to adulthood. Focus on self-determination, independent living skills, work readiness and pre-vocational skills.	• Mos. 36-48	• CMs; HFAA; YC; BCs	• Each FGC has an MOA with 2 community organizations to support local naturally occurring community-based after school/weekend programs.

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• Conduct demonstration program and follow-up study of youth in local naturally occurring community-based programs developed in Year 2.	• Mos. 36-48	• CMs; HFAA; YC; FGC Management Teams	• Data collected quarterly, regarding # and % of youth employed or in higher education/training programs post-discharge.
• Develop a "Kids Helping Kids" youth warm line. • Routine review of service gap reports with particular attention to availability of mental health services in rural communities, with development of services after a gap is identified.	• Mos. 36-48 • Mos. 36-48	• CMs; HFAA; YC • CC; BCs; CRMS; CMD	• Staff and volunteers recruited and trained; Phone line available and running. • 85% of children/youth residing in rural communities, will be served without experiencing gaps in service.
• Implementation of the plan developed in Year 1 to include consultation and technical assistance for pre-schools and other early-childhood programs.	• Mos. 36-48	• CC; BCs; CPDS	• Plan for consultation and technical assistance for pre-schools and other early-childhood programs is implemented.
• Continue use of Block Grant funding to support services to homeless and transgender youth, and for early-intervention services.	• Mos. 36-48	• CC; CCD; CRMS	• 85% of Block Grant performance measures will be achieved.
Goal 3: CAMHD and its provider agencies will consistently apply the current knowledge of evidence-based services in the development of individualized plans. The design of the mental health system will facilitate the application of these services. **3.1** *Achieve the widespread availability of evidence-based services*			
• Continue to conduct training for providers and FGC staff in evidence-based services as identified by CAMHD/EBS.	• Mos. 25-36	• CPDS	• 85% providers and CAMHD staff trained.
• Continue to develop a network of trainers in evidence-based services.	• Mos. 25-36		• One EBS trainer per track whose training services are available to providers.

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• Provide training in evidence-based decision making for FGC staff and prepare them for stakeholder meetings to discuss evidence-based services and principles.	• Mos. 25-36	• EBS Committee Chair; CPDS	• 85% trained and prepared to lead stakeholder discussions; a representative of 75% of stakeholder agencies participates.
3.2 *Establish a mechanism for the ongoing evaluation of the use and effectiveness of evidence-based services.*			
• Continue to assess impact of current practice on family satisfaction through Provider Satisfaction Survey and Family Satisfaction Survey.	• Mos. 36-48	• CCD; HFAA; MIS; CAMHD providers	• Data gathered from 40% of the CAMHD registered population.
• Continue to assess impact of current practice on outcomes, and utilization patterns.	• Mos. 36-48	• CCD; MIS; CRES	• Data gathered from 85% of the CAMHD registered population.
• Conduct review of local evidence of practice impact via established mechanisms through MIS; Train on local evidence report.	• Mos. 36-48	• CCD; EBS Committee Chair; CRES	• Updated report summarizing the local impact of evidence-based approaches is completed and distributed; 55% of CAMHD staff trained
3.3 *Promote the sustained and appropriate application of evidence-based services and principles*			
• Disseminate second review locally and nationally.	• Mos. 36-48	• CCD; EBS Committee Chair; CRES	• Publications and presentations submitted/conducted.
Goal 4: CAMHD and its provider agencies routinely evaluate performance data and apply the findings to guide management decisions and practice development.			
4.1 *Expand and develop an operational evaluation and supervision system based on routine practice measures and timely information that is increasingly clinically relevant and is really exchanged in collaborative relationships with providers and partner agencies.*			
• Monitoring and assessment of clinical processes and clinical/supervision module adherence.	• Mos. 36-48	• CCD; CPM; BCs; QAS	• Increase in the # of clinical reports accessed; increaseduser

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			satisfaction.
• Support electronic sharing including ISPED, descriptions of joint data sets, and system requirements.	• Mos. 36-48	• CC; MIS	• Multi-agency reports developed.
4.2 *A clearly defined, decentralized streamlined quality monitoring and improvement system that involves families, multiple agencies, and internal quality assurance personnel with clear implications for practice and policy decisions in the context of a knowledge-based learning organization.*			
• Sustain family involvement in evaluation and performance management reviews.	• Mos. 36-48	• CPM; HFAA	• Increase in the # of family members involved in the review and evaluation process.
• Sustain Central Office reviews at the State level.	• Mos. 36-48	• CPM; CPISC	• Annual reports completed.
• Refine monitoring protocols as needed.	• Mos. 36-48	• CPM	• Protocols are revised as needed.
• Develop capacity to perform and support special, controlled studies in local areas, including evaluation of prevention, specific populations, and longer-term follow-up.	• Mos. 36-48	• Leadership framework; Community representatives; Research professionals; CRES	• Special study and evaluation reports completed.
• FGC reviews accomplished through internal reviews and internal monitoring.	• Mos. 36-48	• BCs; QAS	• Quarterly reports provided to Central Office.
• Central Office provides validation of internal reviews/FGC reviews and technical assistance/feedback based on a leveling system to determine extent of external monitoring needed.	• Mos. 36-48	• CPM; QAS	• FGC feedback report; Statewide aggregate reports.
• Sustain internal case-based reviews for provider agencies/less external monitoring based on quality performance and self-monitoring.	• Mos. 36-48	• CPM	• Increase in the # of provider agencies conducting internal monitoring using case-based reviews.
4.3 *Stakeholder communications that tell our story of success in a user-friendly, digestible and inspirational fashion to professional, legislative and family groups and incorporate their feedback in measure selection, data*			

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interpretation and system design. • National presentations and publications, build internal capacity through training and increased data availability, partner with external researchers.	• Mos. 36-48	• CRES; CCD; Families; BCs; University and Community College faculty and students CC.	• Increase in # of publications and presentations.
Goal 5: The business practices implemented throughout CAMHD and its provider agencies ensure high quality and accountable operations. **5.1** *All CAMHD staff need to understand their roles and responsibilities, scope of authority, and be held accountable for their performance.*			
• Continued integration of HIPAA requirements into daily practice of CAMHD. • Monitoring of compliance efforts.	• Mos. 37-48	• CMs; QAS; MIS; CPISC	• HIPAA compliance.
• Continue to provide in-service training courses for all of CAMHD staff.	• Mos. 37-48	• CPDS	• 100% of CAMHD staff have received appropriate trainings.
5.2 *Consistent enforcement of fiscal management processes to ensure good business practice, fiscal responsibility, and system accountability.*			
• Appropriate facilitation and application of the competitive bid process.	• Mos. 37-48	• CCMS	• Little to no appeals of RFP awards, or resolution of RFP appeals in CAMHD's favor by the SPO.
• Implement the Utilization Management (UM) Plan to conduct targeted utilization review of most costly services.	• Mos. 37-48	• CRMS; CMs; BCs; FGC Psychiatrists	• Consistent decrease in placements and length of stay in mainland placements, hospital-based residential placements, and out-of-home placements.
• Expansion of resources and service capacity.	• Mos. 37-48	• CRMS; CMs; BCs; FGC Psychiatrists	
• Interaction and collaboration with Juvenile Justice System.	• Mos. 37-48	• CRMS; CMs; BCs; FGC Psychiatrists	
• Consistent oversight of provider agencies.	• Mos. 37-48	• CRMS; CMs; BCs; FGC Psychiatrists	

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• FGC Psychiatrists/Clinical Directors co-manage cases at the higher hospital-based residential level of care.	• Mos. 37-48	• CRMS; CMs; BCs; FGC Psychiatrists	
• Regular review of established thresholds.	• Mos. 37-48	• CRMS; CMs; BCs, FGC Psychiatrists	
• Completion of monthly *Summary of Services*.	• Mos. 37-48	• MIS; CAMHD PHAO V	• *Summary of Services* timely.
• Performance of semi-annual MHCC caseload analysis.	• Mos. 37-48	• PHAO V; BCs	• MHCC caseload analyzed twice a year.
• Fully implement PAS requirements for all CAMHD.	• Mos. 37-48	• CMs; BCs	• 100% of CAMHD staff have updated/current PAS.
• Strict internal adherence to 30-day reimbursement goal.	• Mos. 37-48	• CAMHD PHAO V; MIS	• Decrease in amount of 30-day reimbursement goals missed.
• Consistent monitoring of compliance with each sectional budget.	• Mos. 37-48	• CMs	• All sections within CAMHD are living within their budgets.
• Claim audits will be performed based on a random sample of all claims submitted during the fiscal year, and results will be extrapolated to the full set of claims.	• Mos. 37-48	• CAMHD Compliance Officer; CAMHD PHAO V; CCRU	• Reduction in CAMHD overpayments to providers; No successful challenges to random sampling methodology through CAMHD appeals process or other formal processes.
5.3 *Implementation of a Strategic Management Information Systems Plan that will allow for identification of the appropriate systems direction for the CAMHD and how it can further utilize technologies to facilitate meeting its mission, goals, and objectives.*			
• Website is regularly updated with updated information, news, documents for publishing, and other information for public access.	• Mos. 37-48	• MIS	• Website is current, user-friendly, and accessible.
• Comprehensive computer training of CAMHD staff. • Orientation to CAMHMIS and email for new users. • Oracle Discoverer Training for all users.	• Mos. 37-48	• MIS	• Improvement of CAMHD staff competency in all defined areas; Decrease in requests for MIS assistance in these areas.

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• Microsoft Word training for new users. • Microsoft Excel training for specialty users. • Microsoft Access training for interested specialty users. • Clinical Module training. • Training on new modules as developed.			

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SECTION VIII

APPENDIX

Appendices

A: CASSP Document

B: Accessing CAMHD Services

C: CAFAS Tool (available in hard copy only)

D: Glossary of Terms

E: Reference Documents

Appendix A

STATE OF HAWAII
CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP)
PRINCIPLES

1. The system of care will be child and family centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided.

2. Access will be to a comprehensive array of services that addresses the child's physical, emotional, educational, recreational and developmental needs.

3. Family preservation and strengthening along with the promotion of physical and emotional well-being shall be the primary focus of the system of care.

4. Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.

5. Services which require the removal of a child from his/her home will be considered only when all other options have been exhausted, and services aimed at returning the child to his/her family or other permanent placement are an integral consideration at the time of removal.

6. The system of care will include effective mechanisms to ensure that services are delivered in a coordinated and therapeutic manner, and that each child can move throughout the system in accordance with his/her changing needs, regardless of points of entry.

7. Families or surrogate families will be full participants in all aspects of the planning and delivery of services.

8. As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.

9. Early identification of social, emotional, physical and educational needs will be promoted in order to enhance the likelihood of successful early interventions and lessen the need for more intensive and restrictive services.

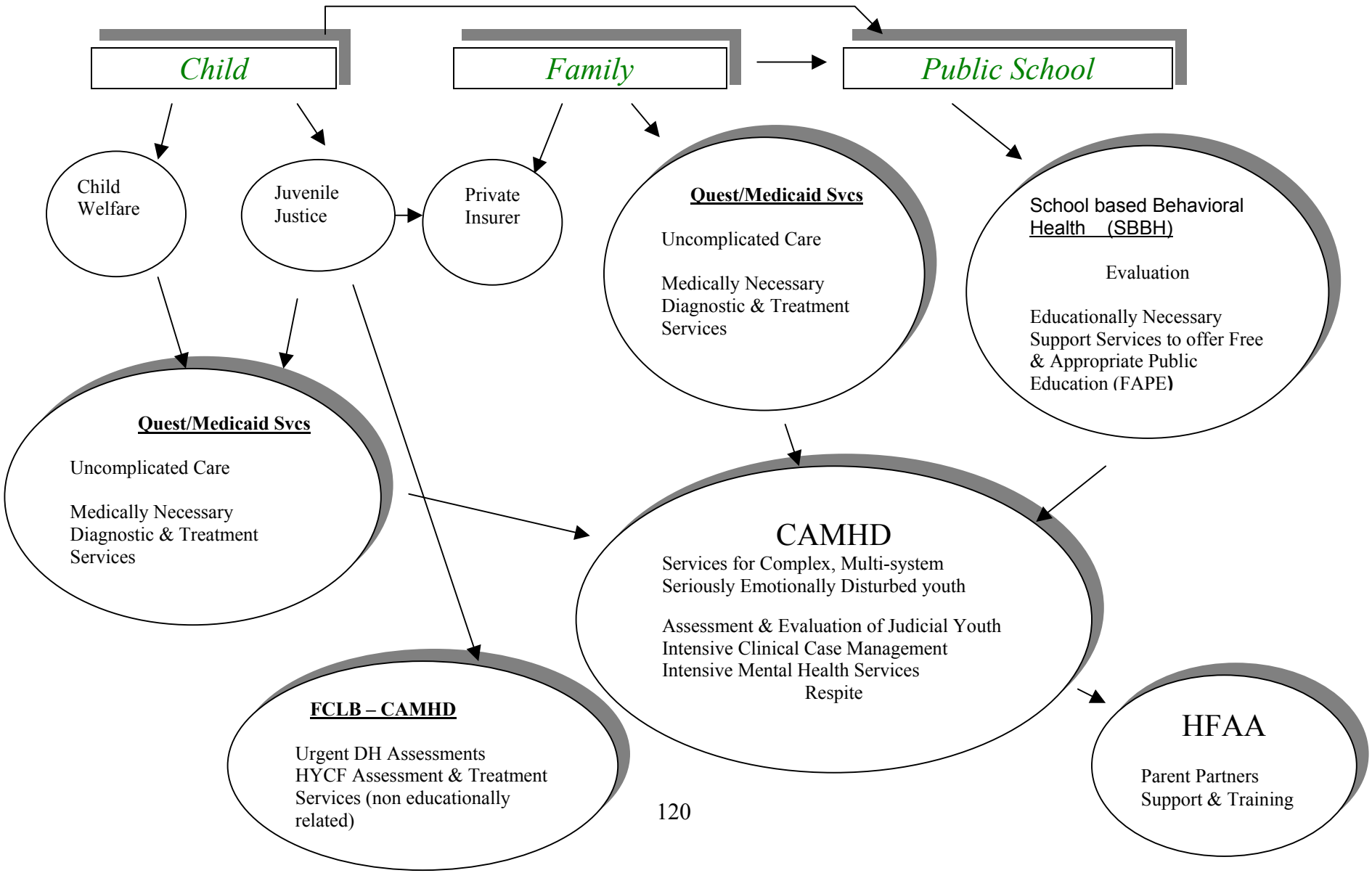
10. The rights of children will be protected and effective advocacy efforts for children will be promoted.

Developed by Hawaii Task Force, 1993.
(Adapted from Stroul, B.A. and Friedman, R.M., 1986)

Appendix B

ACCESSING CHILD & ADOLESCENT MENTAL HEALTH SERVICES

HAWAII'S CHILD SERVING AGENCIES



Appendix D
Glossary

Best Practice - Expert consensus opinion regarding a preferred course of action or standard of care in the absence of research evidence from controlled scientific studies supporting its effectiveness.

Care Coordination - Activities involved in serving as central point of contact for a family. Functions include coordinating the mental health services, linking with all involved child-serving agencies, monitoring provider delivery of service, assisting child/youth and family with accessing and receiving necessary services. Includes home visits, school visits, provider meetings, and routine evaluation of results of service delivery. Often referred to as intensive clinical case management in other agencies.

Child Serving Agencies - Most commonly used to identify the public agencies responsible for various aspects of supporting and serving children and families. Typically implies the Department of Education, Department of Human Services for Child Welfare Services, Child & Adolescent Mental Health Division, Office of Youth Services and Juvenile Justice.

Child/Children - An individual(s) age birth through 12 years.

Community Children's Council (CCC) - The organizational foundation for community participation in the system of care established in accordance with the Felix Consent Decree.

Coordinated Service Plan (CSP) - A written design for service that describes the roles and responsibilities of multiple agencies or programs that provide therapeutic or supportive interventions or activities essential to the youth's and family's treatment.

Coordinated Service Plan (CSP) Process - A process of bringing together the family, multiple agencies and providers, and the child/youth, when appropriate, to develop a comprehensive and integrated plan of individualized care for the child/youth that is based on the child's/youth's strengths and needs.

DSM-IV - A publication titled the Diagnostic and Statistical Manual of Mental Disorders that is used to guide diagnostic formulations of individuals with emotional disorders.

Emotional Disturbance - An emotional or behavioral condition, categorized by a DSM IV diagnosis, which impacts the functioning of many children/youth.

Empirically-Supported Services - A subset of "evidence-based" techniques (see "Evidence-Based" in this Glossary) that have met a particular set of more demanding criteria for their support and use as mental health treatments. These criteria were outlined nationally by the American Psychological Association Task Force on Psychological Intervention Guidelines (1995) and have been adapted locally by CAMHD. The two criteria that distinguish "empirically-supported" from other "evidence-based" techniques are: 1) efficacy, or how well a treatment is known to bring about change in the problem, and 2) effectiveness, or the clinical utility of the intervention. Whereas efficacy is mainly concerned with the quality of treatment in controlled, often university-based programs, effectiveness refers to the expected or observed performance of a treatment in a "real world" setting.

Evidence Based Decision-Making - The process of prioritizing therapeutic services for use based on the quality of national, local, and individual evidence regarding the likely outcomes and effectiveness of those services.

A common example is to give preference to the use of services with clear scientific support in multiple randomized clinical trials or well-controlled clinical series, before services support by non-randomized studies, uncontrolled studies, or expert consensus.

Evidence Based Services - Those strategies and interventions, identified by the EBS Committee, for which credible, published research exists demonstrating positive effects, including uncontrolled, open trials or case studies. For the purposes of the CAMHD, such evidence typically is found only in peer-reviewed scientific journals.

Evidence Based Services (EBS) Committee - An interdisciplinary committee responsible for routinely reviewing and reporting on the scientific literature to identify evidence based services and best practices. Members represent multiple stakeholder groups including CAMHD, DHS, DOE, Family Court, Families, Providers, and the University of Hawaii.

Experienced Staff – Individuals that have worked with a given population in other positions of their professional career.

Health Insurance Portability and Accountability Act (HIPAA) - An Act of Congress that amends the Internal Revenue Code of 1986 in order to improve the portability and continuity of health insurance coverage. The Act primarily seeks to protect the confidentiality and privacy of patient health information and requires the development of a health information system, including the standards and requirements for the secured electronic transmission of certain health information and for policies and procedures in compliance with HIPAA's Privacy Rule.

Individualized Special Education Information System (ISPED) – The Department of Education's information system for collecting core data elements for youth with educational disabilities.

Knowledgeable Staff - Individuals that have been formally educated or received professional training to work with a given population.

Oracle Discoverer - Discoverer is a distributive on line reporting system that allows custom data sets to be reported and manipulated based on access rights. Users have the ability to drill down on specific information or export data sets into Excel.

Performance Appraisal System (PAS) –The Performance Appraisal System provides supervisors with an effective tool to evaluate, and improve, employees' work performance.

Provider(s) - The network of agencies and their subcontractors from which CAMHD purchases direct services for children, youth, and families.

Sentinel Event - An occurrence involving serious physical or psychological harm to anyone or the risk thereof. (See CAMHD Sentinel Events Policy and Procedures for event code definitions and reporting requirements.) A Sentinel Event includes 1) any inappropriate sexual contact between youth, or credible allegation thereof; 2) any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof; 3) any physical or sexual mistreatment of a youth by staff, or credible allegation thereof; 4) any accidental injury to the youth or medical condition requiring transfer to a medical facility for emergency treatment or admission; 5) medication errors and drug reactions; 6) any fire, spill of hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or 7) any incident of elopement by a youth.

Serious Emotional Disturbance or Serious Emotional/Behavioral Disturbance (SED/ SEBD) – An emotional or behavioral condition which greatly impacts the functioning of many children/youth. Typically the individual meets the following criteria:

- From birth to 18 years
  AND
- Who currently, or at any time during the past year have, or had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria of the Diagnostic & Statistical Manual for Manual Disorders, Vol. IV. (DSM IV)
  AND

- This diagnosis resulted in functional impairment ***that substantially*** interferes (d) with, or limits, the child's role or functioning in family, school, or community activities.

AND

- These disorders *exclude* V codes, substance use, and developmental disorders, *unless* they co-occur with another diagnosable serious emotional disturbance.

Stakeholders – Individuals, entities and agencies that have a vested interest in the children's mental health system, including families, community associations, advocacy groups, child serving agencies, and the legislature.

System –The resulting whole, whose elements stay together because they continually affect each other over time and operate toward a common purpose.

System of Care - A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.

Veteran Staff - Individuals that have worked, for a period of time, with a given population in Hawaii's child and adolescent mental health system.

Young Adult – An individual, age 19 to 21 years.

Youth – Most broadly may be used to refer to individuals ages 3 – 20 years, but most commonly use refers to individuals, age 13 through 18 years.

Appendix E

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